PER

The New York
Academy of Medicine

The
Rudolph August Witthaus
Library Fund

Established 1915

JULY, 1967
Volume 54
Number 7

The JOURNAL of the Florida Medical Association

Proceedings Number

Ninety-Third Annual Meeting Bal Harbour

Detailed Index on Page 743

OFFICIAL PUBLICATION OF THE FLORIDA MEDICAL ASSOCIATION



Whether the allergen is greenish or garish, unseen or unknown, your patient can get symptomatic relief with BENADRYL—the potent antihistamine with antispasmodic action. *INDICATIONS:* Antihistaminic, antispasmodic, antitussive, and antiemetic therapy. *PRECAUTIONS:* Persons who have become drowsy on this or other antihistamine-containing drugs, or whose tolerance is not known, should not drive vehicles or engage in other activities requiring keen response while using this product. Hypnotics, sedatives, or tranquilizers if used with diphenhydramine hydrochloride should be prescribed with caution because of possible additive effect. Diphenhydramine has an atropine-like action which should be considered when prescribing diphenhydramine hydrochloride. *ADVERSE REACTIONS:* Side effects are generally mild and may affect the nervous, gastrointestinal, and cardiovascular systems. Drowsiness, dizziness, dryness of the mouth, nausea, nervousness, palpitation, blurring of vision, vertigo, headache, muscular aching, thickening of bronchial secretions, restlessness, and insomnia have been reported. Allergic reactions may occur.

BENADRYL is available in Kapseals® of 50 mg. and Capsules of 25 mg. 00867

The pink capsule with the white band is a trademark of Parke, Davis & Company.

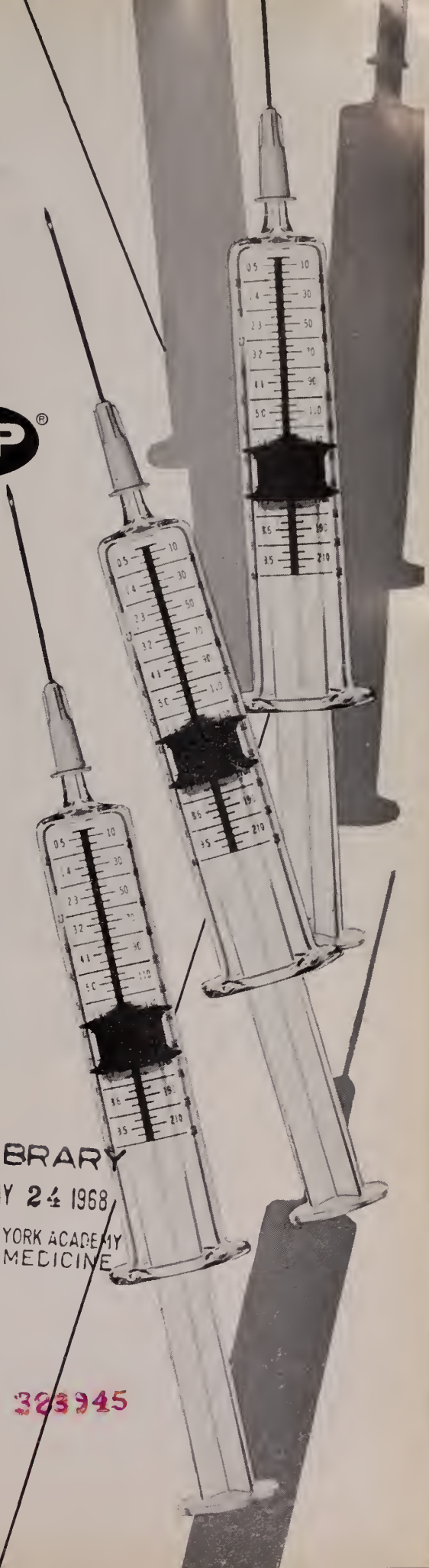
PARKE-DAVIS

SP® DISPOSABLE UNIT

D BRAND OF SODIUM SULFOBROMOPHTHALEIN INJECTION, USP

(50 mg. per ml.)

BSP®



ULPHALEIN®

COMPLETE,

ILE,

OSABLE,

ONOMICAL

ENT-UNIT.

BSP, one of the more valuable single laboratory procedures for determining hepatic function, is now packaged in a complete individual patient-unit.

Each BSP Disposable Unit contains a sterile syringe with the 5 mg./kg. BSP dosage schedule imprinted on the barrel, a sterile needle, alcohol swab and a 7.5 ml. or 10 ml. size ampule of terminally sterilized Bromsulphalein solution.

This all-inclusive disposable put-up lessens the chance of cross-infection and saves time and labor— the most costly commodities.

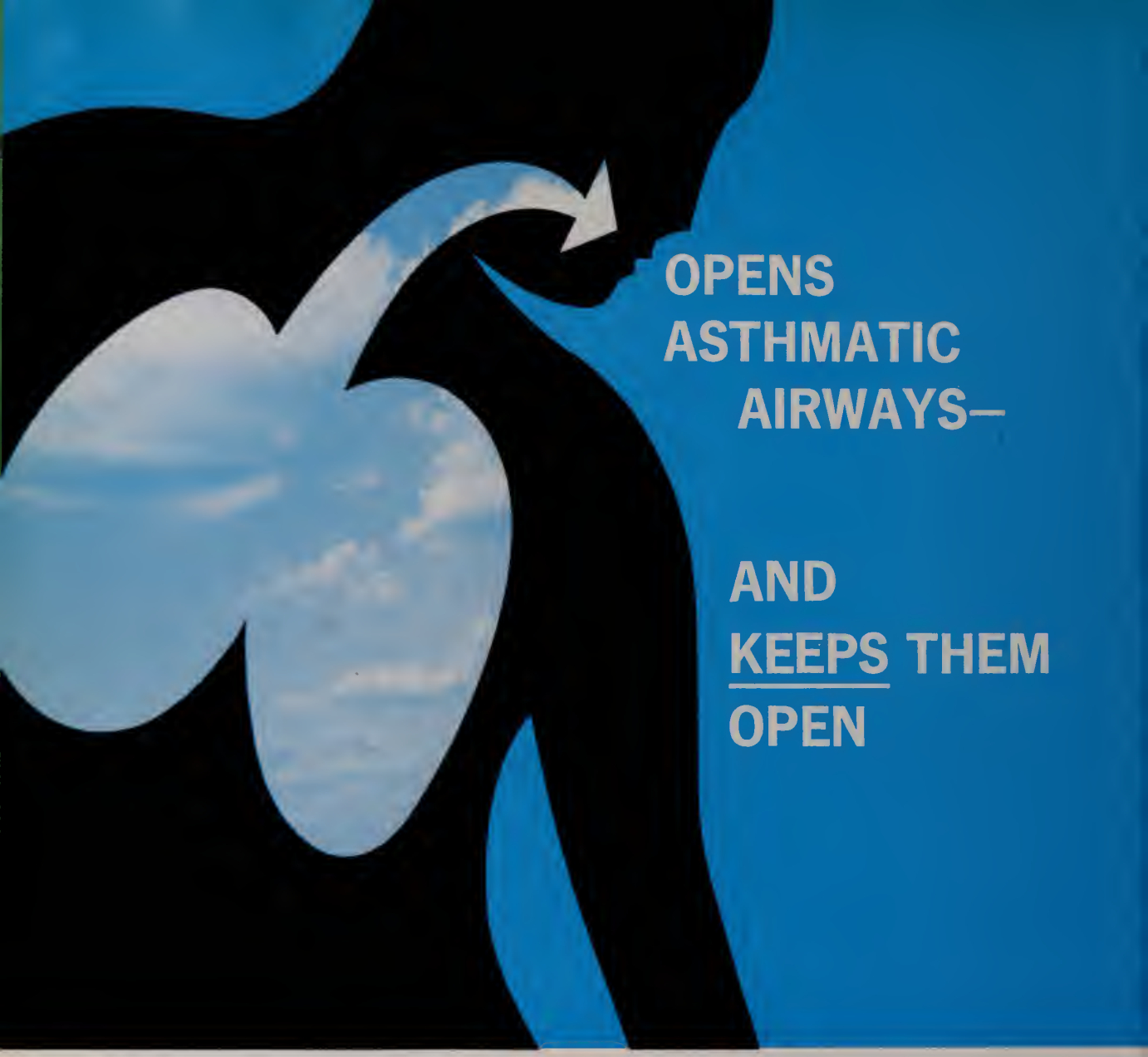
LIBRARY
MAY 24 1968
NEW YORK ACADEMY
OF MEDICINE

323945

NSON, WESTCOTT & DUNNING, INC.

(BSP03)

BALTIMORE, MARYLAND 21201



NUMA® DURA-TABS®

for *prolonged* aid to ventilation

Each Numa Dura-Tab provides:

theophylline	225 mg.
ephedrine HCl	50 mg.
butabarbital	25 mg.

(Warning: butabarbital may be habit-forming.)

Numa Dura-Tabs provide *prolonged* three-way action to ease breathing. Theophylline, a potent bronchodilator with minimal effect on the CNS, opens air passages and reduces bronchial spasm. Ephedrine HCl improves breathing capacity through its decongestant action. Butabarbital, a mild sedative, allays fear and apprehension.

Dosage: One Numa Dura-Tab every 8 to 12 hours helps keep the asthmatic patient symptom-free all day/all night.

Precautions: Use with caution in cardiovascular or hyperthyroid disease, severe hypertension, circulatory collapse, prostatic hypertrophy, or glaucoma.

WYNN Pharmaceuticals, Inc., Phila., Pa. 19132 • Manufacturers of QUINAGLUTE® DURA-TABS®
(Quinidine Gluconate 5 gr.)

The JOURNAL
of the Florida Medical Association

Volume 54, Number 7, July 1967

THIS ISSUE

Annual Meeting Proceedings

President's Address 643
General Session 647
First House of Delegates 653
Second House of Delegates 660

Editorial

Ninety-Third Annual Meeting, E. B. Hardee Jr., M.D. 727

In Memoriam

Homer Lee Pearson, M.D. 651

Departments

President's Page 711
Public Health Topics 627
The Medical Detective 635
Government News 716
Meetings 728
National and Regional Meetings in Florida 728
Deaths 729
Classified 740

Miscellaneous

County Medical Societies of Florida 733
Schedule of Meetings 734
Index to Advertisers 735
Florida Medical Association Officers, Councils and Committees 736
Information for Authors 742
Index to Proceedings 743

THAD MOSELEY, M.D.
Editor

Assistant Editors

JOHN M. PACKARD, M.D.
OSCAR W. FREEMAN, M.D.

Assistant Editor from the Board of Governors
JACK Q. CLEVELAND, M.D.

W. HAROLD PARHAM
Managing Editor

EUGENE L. NIXON
Associate Managing Editor

LOUISE RADER
Assistant Managing Editor

EDITH B. HILL
Editorial Consultant

Published monthly at Jacksonville, Florida. Price $7.00 a year: single numbers, 70 cents. Address Journal of Florida Medical Association, P.O. Box 2411, 735 Riverside Ave., Jacksonville, Fla. 32203. Telephone (904) 356-1571. Accepted for mailing at special rate of postage provided for in Section 1103, Act of Congress of October 3, 1917; authorized October 16, 1918. Entered as second class matter under Act of Congress of March 3, 1879, at the post office at Jacksonville, Florida, October 23, 1924.

Owned and published by the Florida Medical Association, Inc. The Journal is not responsible for the opinions and statements of its contributors.

Wounds, abscess, cellulitis



..and the omplications f staph.

From time of birth, the child is exposed to a whole range of potential staph infections: wounds; secondarily infected dermatoses; primary lesions, such as deep impetigo (ecthyma), boils and felons; and more serious conditions such as osteomyelitis, staph pneumonia and staph meningitis.

Bactericidal

Hardly a staph organism can resist the bactericidal action of Prostaphlin® (sodium oxacillin), as shown by a 34-month *in vitro* study. Of all staph isolates tested, 99.5% were sensitive to oxacillin.[1]

Clinically Proven

There is a high correlation between these *in vitro* findings and clinical results. Of 610 patients treated with Prostaphlin (sodium oxacillin), 89.8% were reported cured or improved, including those with staph infections resistant to penicillin G.[2] And since resistance does not appear to develop *in vivo,* therapy with oxacillin can be extended when necessary.

Outstanding Safety Record

Besides being staph-specific and rapidly absorbed—Prostaphlin (sodium oxacillin) has established an outstanding record of safety during five years of widespread clinical use. Continuous high blood levels of oxacillin have not produced toxic effects on kidney function, assuring a significant margin of safety. However, as with all penicillins, the possibility of allergic response should be considered.

Capsules, Oral Suspension and Injectable

Prostaphlin (sodium oxacillin) is available in three flexible dosage forms to suit the age of the patient and severity of infection—an oral solution for pediatric use, capsules, and multi-dose vials for injection.

PRESCRIBING INFORMATION: For complete information, consult Official Package Circular. *Indications:* Infections caused by Staphylococci, particularly those due to penicillin G-resistant Staphylococci. *Contraindications:* A history of severe allergic reactions to penicillin. *Precautions:* Typical penicillin-allergic reactions may occur. Safety for use in pregnancy and premature infants is not established. Because of limited experience, use cautiously and evaluate organ system function frequently in neonates. Mycotic or bacterial superinfections may occur. Assess renal, hematopoietic and hepatic function intermittently during long-term therapy. *Adverse Reactions:* Skin rashes, pruritus, urticaria, eosinophilia, nausea, vomiting, diarrhea, fever and occasional anaphylaxis. Rare cases of reversible hepatocellular dysfunction have occurred. Moderate SGOT elevations have been noted. Thrombophlebitis has occurred occasionally during intravenous therapy and leukopenia was noted in two cases. *Usual Oral Dosage:* Adults: 500 mg. *q.* 4 or *q.* 6 *h.* Children: 50 mg./Kg./day. *Usual Parenteral Dosage:* Adults: 250-500 mg. *q.* 4 or *q.* 6 *h.* Children: 50 mg./Kg./day. Treat beta-hemolytic streptococcal infections for at least 10 days. Give oral drug 1 to 2 hours before meals. *Supplied:* Capsules—250 and 500 mg. in bottles of 48. Injectable—250 mg., 500 mg., and 1 Gm. dry filled vial for I.M./I.V. use. For Oral Solution—100 ml. bottle, 250 mg./5 ml. when reconstituted. **A.H.F.S. CATEGORY 8:12.16**

References: 1. Abstracted from *Antibiotic Sensitivity of Staphylococci Studied from November 1962 through August 1965,* reported by Griffith, L.J., Staphylococcus Reference Laboratory, V.A. Hospital, Batavia, N.Y. 2. Data on file, Bristol Laboratories.

BRISTOL

BRISTOL LABORATORIES/Division of Bristol-Myers Co., Syracuse, N.Y.

taph reliably ontrolled with pecific therapy



uitable dosage form for every staph situation

Whenever you suspect staph PROSTAPHLIN®

SODIUM OXACILLIN



now Novestrol™ (ethinyl estradiol U.S.P.)

estrogen replacement therapy

for the menopausal syndrome and female hypogonadism. Novestrol, a pure synthetic estrogen derivative, is related to estradiol which is the primary hormone of the ovarian follicle. It is effective orally and has all the actions of naturally occurring estrogen.

Ethinyl estradiol is the most active estrogen known. In addition to its high potency, Novestrol offers patients the advantages of minimal side effects, low cost, and convenience. Usually only a single daily dose is necessary.

Description: Each green, sugar-coated tablet contains 0.02 mg. of ethinyl estradiol U.S.P., a pure synthetic estrogen derivative, the most active estrogen known.
Indications: Menopausal syndrome and female hypogonadism.
Contraindications: Patients with tumors which estrogen might stimulate.
Precautions: Examine patients for mammary or reproductive system neoplasm. Give with great care, if at all, to patients who have precancerous lesions or family history of cancer.

Prolonged administration or high doses may produce anterior pituitary suppression. Endometrial bleeding can usually be avoided by cyclic administration at lowest effective dose and addition of progesterone during last half of cycle. Endometrial hyperplasia may develop in spite of cyclic therapy.
Side Effects: Occasional gastrointestinal disturbances, headache and vertigo. These usually disappear following proper dosage reduction.
Dosage and Administration: Determine minimum effective dose and maintain only as long as necessary.

Menopausal Syndrome: One or two tablets (0.02 or 0.04 mg.) daily. Omit therapy one week each month. Repeat cyclic therapy until satisfactory response is obtained. Advise patient that vaginal bleeding may occur.

Female Hypogonadism: Two tablets (0.04 mg.) one to three times daily for two weeks followed by progesterone for two weeks. Continue cyclic therapy for 3-6 months; then withdraw therapy to determine if normal cycle will be instituted. Additional cyclic therapy may be required in some patients.

WILLIAM H. RORER, INC. Fort Washington, Pa.

Need a pocket watch?



See your jeweler!

Need another car?



Visit your auto dealer!

Need optical services?

GUILD ℞ OPTICIANS ®

Call on an expert —

YOUR GUILD OPTICIAN!

Just as the jeweler is trained in his field, and the auto dealer is knowledgeable in his business, the Guild Optician is an expert in *his.*

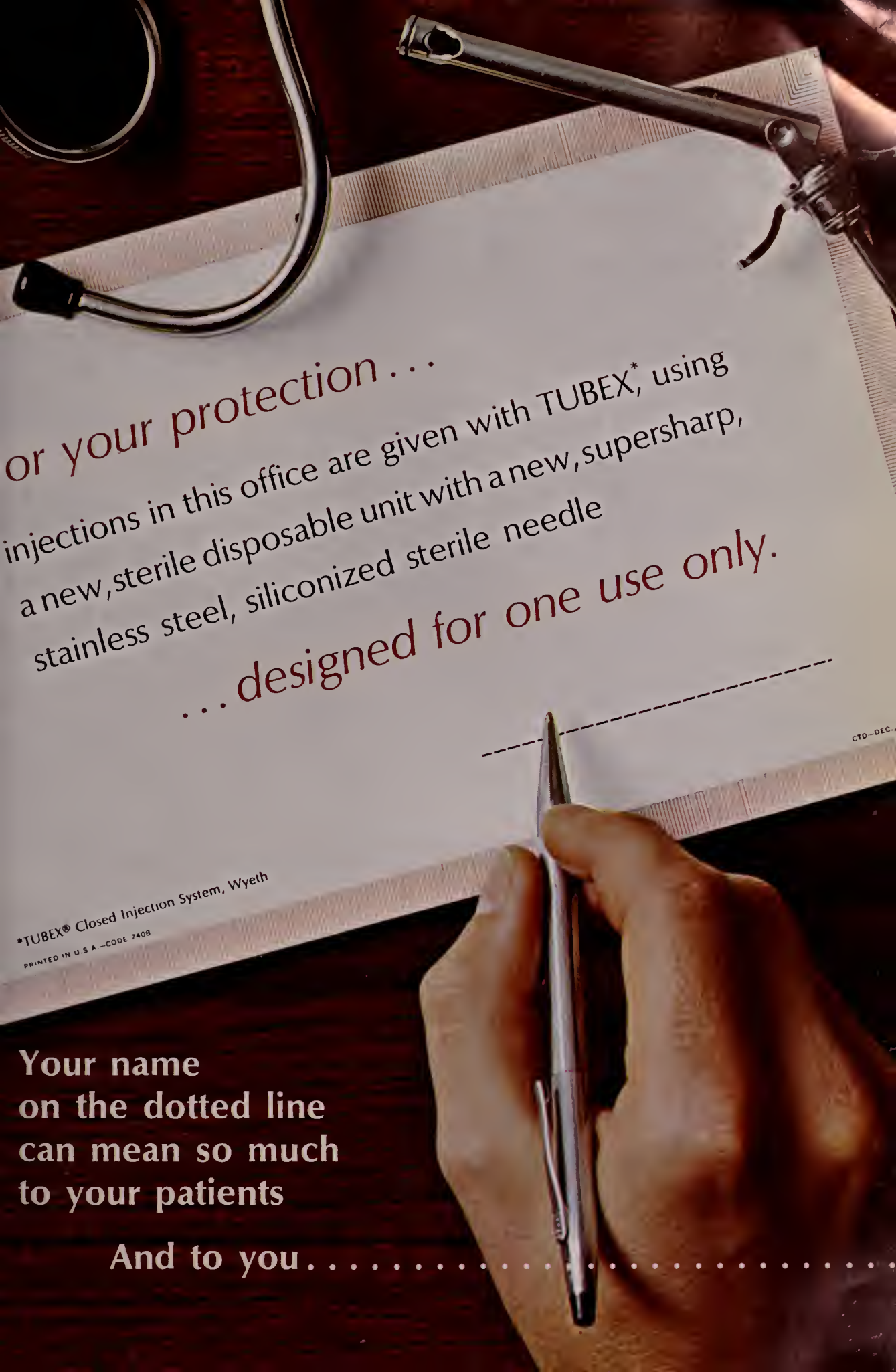
We say "Call on an expert . . ." because your local Guild Optician *is* an expert in mechanical optics. You know he is equipped to handle your most critical cases, both in experience and in training. You know also, because he is a Guild Member, that his standards are high, and that you can depend on him to accurately translate your patient's prescription and to render such after service as your patient might need, for the life of that prescription.

Your local Guild Optician also is an expert at working with your patient in an understanding manner when it comes to the styling and fit of your patient's frame. His stocks reflect not only the most modern fashions, but also the conservative styles that have lasted over the years.

There are, of course, many other areas in which your Guild Optician may be highly skilled: sub-normal vision cases, aphakic cases, contact lenses.

When *you* need optical services, think *first* of your Guild Optician! *Guild of Prescription Opticians of Florida.*

USING GUILD SKILLS AND EXPERIENCE TO SERVE YOUR PATIENTS


or your protection . . .
injections in this office are given with TUBEX*, using
a new, sterile disposable unit with a new, supersharp,
stainless steel, siliconized sterile needle
. . . designed for one use only.
*TUBEX® Closed Injection System, Wyeth
PRINTED IN U.S.A.—CODE 7408
Your name
on the dotted line
can mean so much
to your patients
And to you

. The TUBEX® Closed-Injection System means

Efficiency and convenience

TUBEX injectables are ready for immediate use. No measuring of doses; no filling of syringes. Saves professional time. Easy to store in the office, easy to carry on house calls.

Precision and protection from cross contamination

TUBEX injectables are premeasured, accurately and clearly identified as to name, dose, control number and expiration date (if any). Used once, then discarded, TUBEX prefilled sterile cartridge-needle units cannot cause cross contamination.

Coverage of virtually all injection needs

The wide range of drugs available in TUBEX sterile cartridge-needle units can meet over 70% of common private practice injectable needs. For drugs not yet in TUBEX form, empty sterile cartridge-needle units can usually be employed—and retain most advantages of the system.

TUBEX® Closed Injection System

Wyeth® SERVICE TO MEDICINE

If you are already using TUBEX in your office and don't have a waiting-room placard, Wyeth will be happy to send you one. A postcard will do.

Wyeth Laboratories
Professional Service
Box 8299
Philadelphia, Pa. 19101

UD UNIT-DOSE





Public Health Topics

Research

ALBERT V. HARDY, M.D.

The disastrous epidemic of yellow fever in 1888 had ended; legislators and citizens keenly recognized the need for more effective control methods. The resulting authorization of a Board of Health was an expression of hope that more effective means would be found for preventing such epidemics. Such a search "for more effective means" is applied research, and this has been prominent in the history of the Florida State Board of Health.

During the early years, hookworm disease was prevalent and disabling. J. Y. Porter, Florida's outstanding first State Health Officer, conceived a plan in 1908 "for the amelioration of suffering and to prevent its ravages." The Board would pay $3.00 for the treatment of hookworm disease in each indigent patient. "This makes the one thousand doctors of Florida one thousand missionaries in hookworm work," wrote Dr. Porter. He continued: "For every $3.00 spent, a little hookworm sufferer will be redeemed from the tortures of a living death."

Two years later, the Rockefeller Sanitary Commission, later to become the Rockefeller Foundation, began searching for effective means of dealing with the problem of hookworm disease. An early action was to study procedures used in Florida. Then the Commission sent teams of a physician, nurse and laboratory technician from county to county in neighboring states to examine excreta for hookworm eggs and provide treatment for infected patients. It was soon evident that permanent teams were needed. On a trial basis in North Carolina, comparable units were established in 10 counties. Thus began the development of county health departments in the United States.

In the earlier days, malaria had vied with hookworm disease as the most common and debilitating disorder among the people of rural Florida. Investigation into this infection was the more traditional research supported by the Rockefeller Foundation from 1931 to 1947 with Dr. Mark Boyd in charge. The Malaria Research Laboratory was located at what is now Florida State University. The program was productive in basic and applied research and served as a training center for malariologists, so urgently needed during World War II.

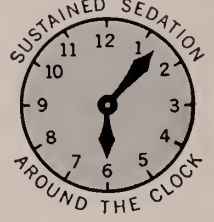
For research today, the Entomological Research Center at Vero Beach is a natural successor to the laboratory at Tallahassee. Established in 1953, the center had for its ultimate objective the more effective control of pests and disease-carrying insects, particularly mosquitoes. It has attained recognition as one of the outstanding entomolog-

removes the mental blur

that clouds vision

SOLFOTON®

Each tablet or capsule contains
PHENOBARBITAL.....16 mg.
(Warning: may be habit forming)
BENSULFOID® (See P D R).....65 mg.
Precaution: same as 16 mg. of phenobarbital



Constructive Therapy

A Solfoton tablet or capsule at 6 hour intervals maintains sedation at the threshold of calmness, sustaining a mental climate for purposeful living.

Literature and clinical samples sent upon request.

FEDERAL LAW PROHIBITS DISPENSING WITHOUT PRESCRIPTION

AVAILABLE

Solfoton *(yellow, uncoated tablets "P")*
100s, 500s, 5000s

Solfoton Capsules *(yellow and brown)*
100s, 500s, 1000s

Solfoton S/C *(sugar-coated beige tablets)*
100s, 500s, 4000s

WM. P. POYTHRESS & CO., INC.
RICHMOND, VIRGINIA 23217
Manufacturers of ethical pharmaceuticals since 1856

ical research laboratories in the nation and in the world. Following the sound practice of locating the laboratory where problems are most troublesome, a second facility is operating at Panama City to give comparable attention to insects presenting particular problems in West Florida.

Responding to the concern caused by a "modern" epidemic, the Encephalitis Research Center at Tampa was established in 1962 immediately following a serious outbreak of St. Louis encephalitis in the counties bordering Tampa Bay. Had it been designed specifically for prevention of St. Louis encephalitis, it would be judged highly effective. The viral agent has disappeared completely from the environment. If reintroduced, it has not been established in insects, animals or man to the extent that its presence can be confirmed. A significant finding in studies conducted at the laboratory is the number of presumably viral infections of the central nervous system which, after exacting investigation, must be classified as etiology undetermined. This unknown area calls for continuing investigation.

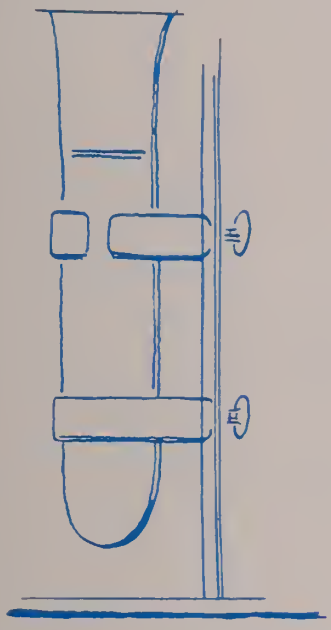
With extended use of pesticides in agriculture and about the home, concern has been growing regarding the possible harmful effect of continued minimal exposure. This study in a limited number of localities about the nation is being sponsored by the U. S. Public Health Service. Investigations in Florida, chiefly in the Dade County Health Department, are regarded as pioneering and outstanding.

Profitable research closely related to service programs has not been neglected. There is a disease entity clinically indistinguishable from pulmonary tuberculosis due to bacteria which simulate the tubercle bacillus but are readily differentiated from it by current culture procedures. These infections are identified predominantly through the examinations for tuberculosis, and data are collected during the relatively routine follow-up of tuberculosis and tuberculosis-like diseases. The study has significant importance and is conducted as a special project within the Board of Health.

The true value of research is not measured in terms of money spent; however, research cannot progress without adequate funds. Grants to the Florida State Board of Health predominantly from the National Institutes of Health amount to about two thirds of a million dollars annually; additional funds from multiple sources increase

the total for research to more than a million dollars per year. From the beginning, the Encephalitis Research Center derived a major portion of its support from NIH. Grants to the Entomological Research Center have progressively increased, now exceeding other sources of its budget. These funds support one part of the State Board of Health's continuing endeavor to find more effective means to protect the health of Florida's citizens and guests to the state.

▸ Dr. Hardy, Florida State Board of Health, Jacksonville 32201.



mudrane®

for

- EMPHYSEMA
- ASTHMA
- CHRONIC BRONCHITIS
- BRONCHIECTASIS

The fast-disintegrating uncoated tablet gives relief in 15 minutes

Each tablet contains:

Potassium Iodide	195 mg.
Aminophylline	130 mg.
Phenobarbital, Caution: May be habit forming	21 mg.
Ephedrine HCl	16 mg.

FEDERAL LAW PROHIBITS
DISPENSING WITHOUT PRESCRIPTION

Precautions: Usual for aminophylline-ephedrine-phenobarbital. Iodides may cause nausea, long use may cause goiter. Discontinue if symptoms of iodism develop.

Iodide contraindications: tuberculosis, pregnancy.

DOSAGE

One tablet, with full glass of water, 3 or 4 times daily.

Dispensed in bottles of 100 and 1000 tablets.

MUDRANE GG—Formula, dosage and package identical to Mudrane—*except*—100 mg. glyceryl guaiacolate replaces the potassium iodide. The value of Mudrane cannot be enjoyed by a small group in which K.I. is contraindicated. Mudrane GG is prepared for this group.

MUDRANE GG ELIXIR—Four 5 cc teaspoonfuls is equivalent to one Mudrane GG tablet. Dosage adjusted to age and weight of child. Mudrane GG Elixir is for pediatric patients and those who think they cannot swallow tablets. Dispensed in pint and half gallon bottles.

WM. P. POYTHRESS & CO., INC.
RICHMOND, VIRGINIA 23217
Manufacturers of ethical pharmaceuticals since 1856

Don't let monilia cut broad-spectrum therapy short...

start with Tetrex-F®

tetracycline phosphate complex-nystatin

Use of broad-spectrum antibiotics can cause fungal overgrowth in the alimentary tract... and give rise to symptoms so troublesome that therapy must be prematurely stopped. Tetrex-F (tetracycline phosphate complex-nystatin) helps you circumvent this problem.

The nystatin can prevent overgrowth of monilia; the phosphate complex delivers tetracycline to the blood rapidly. Side effects are infrequent.

High-Risk Patients

Tetrex-F (tetracycline phosphate complex-nystatin) is especially useful in patients most susceptible to fungal overgrowth during tetracycline therapy: (1) the elderly or debilitated, (2) young children, (3) the diabetic, (4) those on long-term tetracycline therapy, (5) those on steroid therapy, (6) those who have had moniliasis before, and (7) pregnant patients with a history of monilial vaginitis.

When you start with economical Tetrex-F (tetracycline phosphate complex-nystatin), you can complete the full course of broad-spectrum therapy with less chance of losing control elsewhere. A good start for a healthy finish.

PRESCRIBING INFORMATION. For complete information consult Official Package Circular. *Indications:* Infections of respiratory, gastrointestinal and genitourinary tracts and skin and soft tissues due to tetracycline-sensitive organisms, in patients with increased susceptibility to monilial infections. *Contraindications:* The drug is contraindicated in patients hypersensitive to its components. *Warnings:* Photodynamic reactions have been produced by tetracyclines. Natural and artificial sunlight should be avoided during therapy. Stop treatment if skin discomfort occurs. With renal impairment, systemic accumulation and hepatotoxicity may occur. In this situation, lower doses should be used. Tooth staining and enamel hypoplasia may be induced during tooth development (last trimester of pregnancy, neonatal period and childhood). *Precautions:* Bacterial superinfections may occur. Infants may develop increased intracranial pressure with bulging fontanels. In gonorrheal therapy, serologic tests for syphilis should be conducted initially and monthly for 3 months. *Adverse Reactions:* Glossitis, stomatitis, nausea, diarrhea, flatulence, proctitis, vaginitis, dermatitis, and allergic reactions may occur. *Usual Adult Dosage:* 1 capsule q.i.d. Continue for 10 days in Beta-hemolytic streptococcal infections. Administer one hour before or two hours after meals. *Supplied:* Capsules, bottles of 16 and 100. Each capsule contains tetracycline phosphate complex equivalent to 250 mg. tetracycline HCl activity and 250,000 units of nystatin. For Oral Suspension, 125 mg. tetracycline and 125,000 u. nystatin/5 ml., 60 ml. bottles.

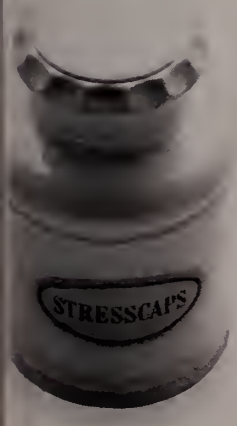
BRISTOL

BRISTOL LABORATORIES
Division of Bristol-Myers Company
Syracuse, New York 13201



in chronic illness

B and C vitamins are part of therapy: An imbalance of water-soluble vitamins and chronic illness often go hand in hand. STRESSCAPS capsules, containing therapeutic quantities of vitamins B and C, are formulated to meet the increased metabolic demands of patients with physiologic stress. In chronic illness, as with many stress conditions, STRESSCAPS vitamins are therapy.



Stresscaps®

Stress Formula Vitamins Lederle

FOR PROFESSIONAL RECOMMENDATION ONLY

Each capsule contains:

Vitamin B_1 (as Thiamine Mononitrate)	10 mg
Vitamin B_2 (Riboflavin)	10 mg
Vitamin B_6 (Pyridoxine HCl)	2 mg
Vitamin B_{12} Crystalline	4 mcgm
Vitamin C (Ascorbic Acid)	300 mg
Niacinamide	100 mg
Calcium Pantothenate	20 mg

Recommended intake: Adults, 1 capsule daily, for the treatment of vitamin deficiencies. Supplied in decorative "reminder" jars of 30 and 100; bottles of 500.

LEDERLE LABORATORIES, A Division of American Cyanamid Company, Pearl River, New York

Lederle

628-6—3614



Perhaps there have been times when you wanted to prescribe erythromycin and triple sulfas for little patients. Now you can—with a choice of two new fine-tasting pediatric forms.

New–Two Pediatric Forms of Erythromycin and Triple Sulfas





RYTHROCIN®-SULFAS hewable (Erythromycin ethyl ccinate-trisulfapyrimidines chewable blet)

clinical trials[1,2], this orange-flavored blet was given to 55 patients, aged ur months to 18 years.

agnoses (multiple in some cases) presented a cross section of bacterial ections commonly seen in pediatric ice practice.

erapy was given from three to 12 ys, with an average of six days.

the 55 patients, 30 were reported red within 72 hours, while 22 showed rtial recovery within the same time, d subsequent clinical cure.

clinical cure rate of 94.5%

ase Reports on File, Dept. Clin. Development, bbott Laboratories.

olley, R.F.L., Use of Erythromycin-Sulfas in Office ractice, Western Med., 7:177, July, 1966.

ERYTHROCIN®-SULFAS Granules (Erythromycin ethyl succinate-trisulfapyrimidines granules for oral suspension)

87 patients were treated[1,2]—all children, ages four months to 15 years.

The diagnoses were multiple in some cases and were chiefly bacterial infections of the respiratory tract.

Dosage was maintained from three to 10 days; average treatment was five days. All of the ill children accepted the orange-flavored suspension favorably.

53 were clinically cured within 72 hours, while 32 showed partial relief within the same time, and subsequent clinical cure.

701358

A clinical cure rate of 97.7%

ABBOTT

Brief Summary on next page

ERYTHROCIN®-SULFAS
Brief Summary

Contraindications: Known sensitivity to erythromycin or sulfonamides. Because of the possibility of kernicterus with sulfonamides, do not use in pregnancy at term, premature or newborn infants.

Warnings: As with other forms of sulfonamide therapy, carefully evaluate patients with liver or kidney damage, urinary obstruction, or blood dyscrasia. Deaths have been reported from hypersensitivity reactions and blood dyscrasias following use of sulfonamides. Perform blood counts and liver and kidney function tests if used repeatedly at close intervals or for long periods.

Precautions, Side Effects: Occasionally mild abdominal discomfort, nausea or vomiting may occur with erythromycin, generally controlled by reduction of dosage. Mild allergic reactions (such as urticaria and other skin rashes) may occur. Serious allergic reactions have been extremely infrequent. Use sulfonamides with caution in patients with a history of allergy. Assure adequate fluid intake to prevent crystalluria and institute alkali therapy if indicated. If overgrowth of nonsusceptible organisms occurs, withdraw the drug and institute appropriate treatment. If a patient should show signs of hypersensitivity, appropriate countermeasures (e.g. epinephrine, steriods, etc.) should be administered and the drug withdrawn.

Adverse Reactions: Sulfonamide therapy may be associated with headache, nausea, vomiting, urticaria, diarrhea, hepatitis, pancreatitis, blood dyscrasias, neuropathy, drug fever, skin rash, injection of the conjunctiva and sclera, petechiae, purpura, hematuria and crystalluria.

Side effects due to erythromycin are infrequent, but occasional abdominal discomfort, nausea, or vomiting, urticaria and other skin rashes may occur.

Supplied: The Granules for Oral Suspension come in bottles of 60 ml. and 150 ml. The Chewable tablets are in bottles of 50. Each 5-ml. teaspoonful of reconstituted Granules or each Chewable tablet provides erythromycin ethyl succinate equivalent to 125 mg. of erythromycin activity and 167 mg. of each of sulfadiazine, sulfamerazine and sulfamethazine.

701358

ABBOTT

Tandearil®
oxyphenbutazone

Therapeutic Effects: Tandearil is a nonhormonal compound which may rapidly resolve inflammation and help restore normal joint function. Its action does not affect pituitary-adrenal function or impair immune responses. Its value in osteoarthritis is especially noteworthy because this disorder responds inconsistently to steroids and is often resistant to salicylates. Further, indomethacin is limited only to osteoarthritis of the hip, whereas oxyphenbutazone is effective in all forms of the disease.

Contraindications: Edema; danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. The drug should not be given when the patient is senile or when other potent drugs are given concurrently.

Warning: If coumarin-type anticoagulants are given simultaneously, watch for excessive increase in prothrombin time. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea, sulfonamide-type agents and insulin. Carefully observe patients receiving such therapy. Use with great caution in the first trimester of pregnancy.

Precautions: Obtain a detailed history and a complete physical and laboratory examination, including a blood count. The patient should be closely supervised and should be warned to report immediately fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools or other evidence of intestinal hemorrhage. Make regular blood counts. Discontinue the drug and institute countermeasures if the white count changes significantly, granulocytes decrease, or immature forms appear. Use greater care in the elderly and in hypertensives.

Adverse Reactions: The most common are nausea, edema and drug rash. The drug has been associated with peptic ulcer and may reactivate a latent peptic ulcer. Infrequently, agranulocytosis, or a generalized allergic reaction may occur and require withdrawal of medication. Stomatitis, salivary gland enlargement, vomiting, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported but cannot definitely be attributed to the drug. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hyperglycemia, hepatitis, jaundice, and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently. Moderate lowering of the red cell count due to hemodilution may occur.

Dosage in Osteoarthritis: The initial daily dosage in adults is 300-600 mg. in divided daily doses. When improvement occurs, dosage should be decreased to the minimum effective level; this should not exceed 400 mg. daily, and is often achieved with only 100-200 mg. daily.

For complete details, please refer to full prescribing information. 6562-VI(B)R

Availability: Tablets of 100 mg.

Geigy

Geigy Pharmaceuticals
Division of Geigy Chemical Corporation
Ardsley, New York

Geigy

Tandearil®
oxyphenbutazone

helps osteoarthritic joints move again



3 out of 4 osteoarthritics completely or markedly improved

Sperling, I.L.: 3 Years' Experience with Oxyphenbutazone in the Treatment of Rheumatic Disorders, Applied Therapeutics 6:117, 1964.	76.9% of 407 patients
Watts, T.W., Jr.: Treatment of Rheumatoid Disorders with Oxyphenbutazone, Clin. Med. 73:65, 1966.	84.6% of 39 patients

Please see adjoining page for brief prescribing summary

TA-4919 PC

Against these three major pathogens...



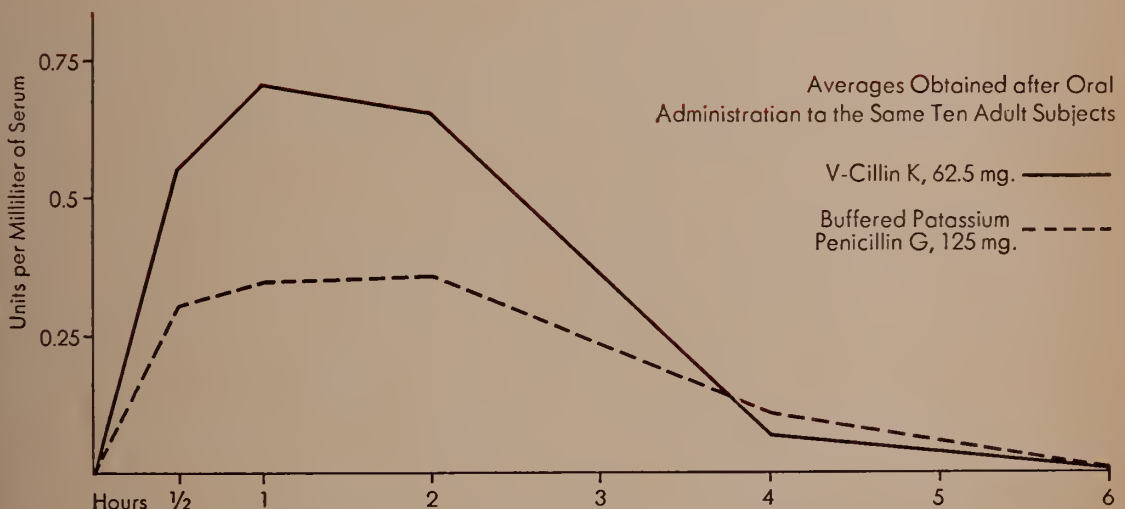
V-Cillin K® provides dependable oral antibacterial activity

because it combines a high degree of in-vitro activity...

Antibiotic	Staph. Aureus (Penicillin-Sensitive) MIC (mcg./ml.) Median	Range	Streptacaccus, Graup A MIC (mcg./ml.) Median	Range	Diplacaccus Pneumaniae MIC (mcg./ml.) Median	Range
Penicillin V	0.02	0.02-0.04	0.02	0.003-0.4	0.01	0.005-0.2
Penicillin G	0.02	0.005-1.6	0.005	0.002-0.2	0.02	0.01-0.1
Methicillin	1.6	0.4-6.3	0.2	0.1-0.4	0.2	0.1-1.6
Oxacillin	0.4	0.1-3.1	0.04	0.02-0.4	0.1	0.04-0.8
Claxacillin	0.2	0.2-0.8	0.1	0.1-0.8	—	—
Nafcillin	0.4	0.2-0.8	0.04	0.02-0.1	0.02	0.02-0.2
Ampicillin	0.2	0.1-0.8	0.02	0.01-0.04	0.02	0.01-0.04

Adapted from Klein, J. O., and Finland, M.: New England J. Med., 269:1019, 1963.

with high blood levels, even in the presence of food



Adapted from Griffith, R. S., and Black, H. R.: Current Ther. Res., 6:253, 1964.

V-Cillin K® Lilly 700636

Potassium Phenoxymethyl Penicillin

(See next page for prescribing informati

New 500 mg. tablets...a more convenient way to give high doses



Description: V-Cillin K is the potassium salt of V-Cillin® (phenoxymethyl penicillin, Lilly). This chemically improved form cambines acid stability with immediate salubility and rapid absorption. Higher serum levels are obtained more rapidly with this penicillin than with equal aral doses af penicillin G. The higher serum levels and acid stability of V-Cillin K make it a more dependable penicillin far oral use.

V-Cillin K, Pediatric, is an oral solution of clinically praved V-Cillin K in teaspoan dosage form. When mixed as directed, each 5 cc. (appraximately ane teaspoonful) will contain 125 mg. (200,000 units) phenoxymethyl penicillin as the potassium salt.

Indications: V-Cillin K has been shown to be effective in the treatment af streptocaccus, pneumocaccus, and ganococcus infections as well as infections caused by sensitive strains of staphylacacci. It may be used for the prophylaxis of streptacaccus infectians in potients with a history af rheumatic fever and far the prevention af bacterial endocarditis after tonsillectomy and toath extraction in those patients with a history af rheumatic fever or congenital heart disease.

Contraindication: V-Cillin K should not be administered to a patient with a history of penicillin hypersensitivity.

Warnings: In rare instances, the use of penicillin may cause acute anaphylaxis which may prove fatal unless promptly cantrolled. This type of reaction appears more frequently in patients with a histary af sensitivity reactions to penicillin and in those with branchial asthma or ather allergies. Resuscitative drugs should be readily available for emergency administration. These include epinephrine and pressor drugs (as well as oxygen for inhalation) far relief of immediate allergic manifestations and antihistamines ond corticosteroids for deloyed effects.

Precautions: V-Cillin K should be used coutiously, if ot all, in a potient with a strongly positive history of allergy.

In prolonged therapy with penicillin, and particulorly with hi parenterol dosoge schedules, frequent evaluation of the renol a hematopoietic systems is recommended.

In suspected staphylococcus infections, proper laboratory studi (including sensitivity tests) should be performed.

The use of penicillin may be associated with the overgrowth pencillin-insensitive organisms. In such cases, its administration shou be discontinued, and appropriate measures should be taken.

Adverse Reactions: Although serious allergic reactions are much le common with administratian of arol penicillin than with intramuscul forms, manifestotions of penicillin allergy may occur.

Penicillin is a substance of low toxicity, but it does possess a sign cant index of sensitization. The following hypersensitivity reactio associated with the use of penicillin have been reported: skin rash ranging from maculopapular eruptions to exfoliative dermatitis; u coria; and reactions resembling serum sickness, including chills, fev edema, arthralgia, and prostration. Severe and often fatal anaphylo has occurred (see Warnings). Hemolytic anemia, leukopenia, thro bocytopenia, and nephropathy are rorely observed side-effects a are usually ossociated with high parenteral dosage.

Administration and Dosage: For Tablets V-Cillin K ond for V-Cillin Pediatric, the usual dosage ranges from 125 mg. (200,000 units) th times a day to 500 mg. (800,000 units) every four hours. For infar the daily dosage may be 50 mg. per Kg. of body weight divided i three doses.

Beta-hemolytic streptococcus infections without associoted b teremia may be treated with 200,000 to 400,0000 units three times day. Therapy should be continued for a minimum of ten days to prev develapment af rheumatic fever and/or ather serious camplicatio Dosage for routine streptococcus prophylaxis in patients with a hist of rheumatic fever or congenital heart disease may be 200,000 u once or twice daily. When such patients undergo tonsillectomy, to extraction, or other minor surgery, the prophylactic dose should 500,000 units every six hours given two days prior to surgery and two days postoperatively. If oral medication is not feasible an the d of surgery, parenteral therapy should be considered. Mild to moc ately severe pneumococcus pneumania has been treated effectiv with 250 mg. every six hours.

In staphylococcus infectians, 400,000 units or more should be gi every six to eight hours in canjunction with indicated surgical pro dures.

For gonorrhea in males, 500 mg. (800,000 units) every four hours three doses may be employed; in females, 500 mg. every faur ho for six doses are recommended. Refractary infections generally resp to a secand treatment three to four days fallowing completion of first. Treatment of gonarrhea with severe camplications should individualized, with prolonged and intensive treatment. Patients wi suspected lesion af syphilis should have a dark-field examination fore receiving penicillin and monthly serologic tests for a minimu three months.

How Supplied: Tablets V-Cillin K, U.S.P., 125 mg. (200,000 units) bottles of 50 and 100; and 250 mg. (400,0000 units) and 500 (800,000 units), in bottles af 24 ond 100.

V-Cillin K, Pediatric, for Oral Solution, 125 mg. (200,000 units) 5 cc. of solution, in 40, 80, and 150-cc.-size packoges. [032

Additianal inlarmation available ta physicians upan request. Eli Lilly and Campany, Indianapalis, Indiana 46206.

Lilly

The Medical Detective



Problems in the Blue

With the frequency of air travel, both commercial and private, we physicians must be increasingly aware of the problems of this environment. Such problems may range from an aerotitis, with which one may be plagued when flying with a cold or infection of the upper respiratory tract, to acute sickle cell crisis in a patient with sickle cell anemia who may be exposed to hypoxic conditions during a flight.

Problems also arise with the responsibility of investigating an aviation accident. One would imagine that such investigation would be predominantly related to commercial or military accidents, yet a large percentage of accidents is related to private aircraft.

The immediate objective of any accident investigation is to determine the cause and contributing factors; the secondary objective is the possible prevention of similar future accidents through hazard elimination. The human factor, technical or mechanical factors and atmospheric conditions all must be considered.

The pathologist has a role in the accident investigating team, in addition to identification, through evaluation of the human's part in the accident. This may include determination of the presence of chronic or acute natural disease, gunshot wounds, high alcohol levels, anoxia, carbon monoxide and or drug intake as well as injuries which may have been prevented, such as fat embolization and explosive decompression.

An interesting case took place one sunny day at a county airport when a four-seater private plane was taking off. As it reached an altitude of approximately 500 feet, it was seen to stall and dive toward the ground. The pilot apparently recovered enough control to make a pancake landing in a large field adjacent to the airport. The aircraft landed wheels-up with only superficial damage.

The pilot's shoulder straps apparently failed. He struck the instrument panel, suffered severe chest injuries, and died soon after arrival at the hospital.

The pilot was alone in the plane. He was a veteran pilot, age 34, who was making a routine flight to pick up a business associate. The postmortem examination was made by a pathologist who was a Federal Aviation Agency approved investigator. Findings included abrasions on the chest, indicating impact injury, with fracture of the sternum and multiple rib fractures. The apparent cause of death was related to the bilateral hemothorax and pleuropericarditis secondary to lung puncture and rupture of the left atrium. The heart was enlarged and flabby with no appreciable arteriosclerosis. The pathologist was curious as to this latter finding. Several sections run on the cryostat quick section microtome revealed a diffuse acute myocarditis. This finding immediately suggested that the human factor was the main cause of the accident. Pilot failure was thus the working impression as investigation of the cause of the accident began.

During a routine check of the plane, a completely plugged fuel line was found, explaining the stall and sudden loss of power. Had the plane burned, no doubt this evidence would have been destroyed, thus placing the blame upon the pilot as related to a natural disease process.

The discovery of the defect and the resulting shift of responsibility had important economic overtones. The insurance claim in behalf of the pilot's widow was not contested. The death was signed out as accidental and the victim's estate was not held liable for the accident.

William G. Eckert, M. D.

In managing tense, anxious patients here's one combination that makes sense: your understanding counsel and **Serax**®

(oxazepam) Wyeth

When prescribing, carefully observe dosage recommendations and appropriate precautions, especially as pertaining to the elderly (see Wyeth literature or PDR as well as "IN BRIEF" below).

IN BRIEF.

Contraindications: History of previous hypersensitivity to oxazepam. Oxazepam is not indicated in psychoses.

Precautions: Hypotensive reactions are rare, but use with caution where complications could ensue from a fall in blood pressure, especially in the elderly. Withdrawal symptoms upon discontinuation have been noted in some patients exhibiting drug dependence through chronic overdose. Carefully supervise dose and amounts prescribed, especially for patients prone to overdose; excessive, prolonged use in susceptible patients (alcoholics, ex-addicts, etc.) may result in dependence or habituation. Reduce dosage gradually after prolonged excessive dosage to avoid possible epileptiform seizures. Withdrawal symptoms following abrupt discontinuance are similar to those seen with barbiturates. Caution patients against driving or operating machinery until absence of drowsiness or dizziness is ascertained. Warn patients of possible reduction in alcohol tolerance. Safety for use in pregnancy has not been established.

Not indicated in children under 6 years; absolute dosage for 6- to 12-year-olds not established.

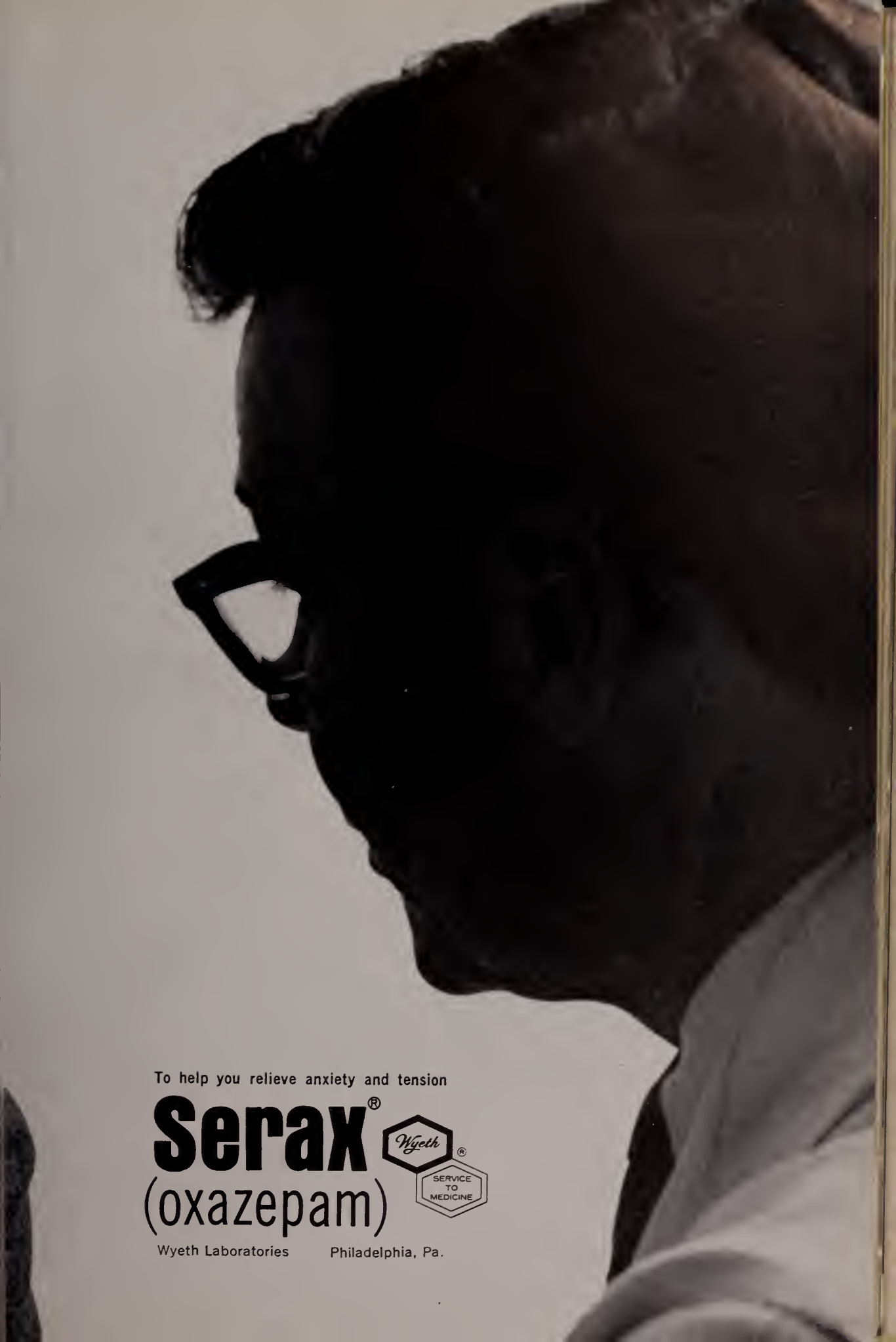
Side Effects: Therapy-interrupting side effects are rare. Transient mild drowsiness is common initially; if persistent, reduce dosage. Dizziness, vertigo and headache have also occurred infrequently; syncope, rarely. Mild paradoxical reactions (excitement, stimulation of affect) are reported in psychiatric patients. Minor diffuse rashes (morbilliform, urticarial and maculopapular) are rare. Nausea, lethargy, edema, slurred speech, tremor and altered libido are rare and generally controllable by dosage reduction. Although rare, leucopenia and hepatic dysfunction including jaundice have been reported during therapy. Periodic blood counts and liver function tests are advised. Ataxia, reported rarely, does not appear related to dose or age.

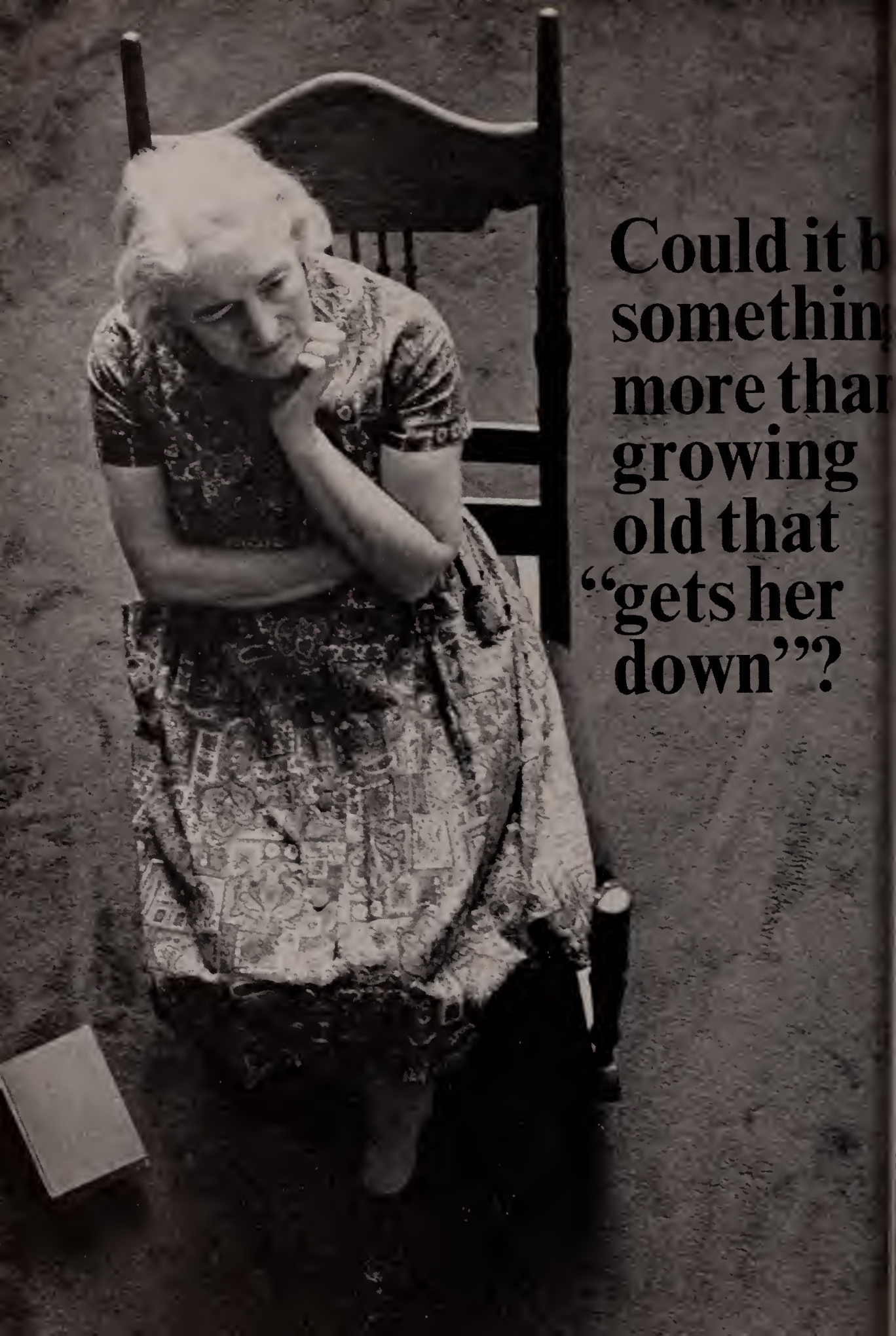
These side reactions, noted with related compounds, are not yet reported: paradoxical excitation with severe rage reactions, hallucinations, menstrual irregularities, change in EEG pattern, blood dyscrasias (including agranulocytosis), blurred vision, diplopia, incontinence, stupor, disorientation, fever and euphoria.

Availability: Capsules of 10, 15 and 30 mg. oxazepam.

Photograph posed by professional models.




To help you relieve anxiety and tension
Serax®
(oxazepam)
Wyeth®
SERVICE TO MEDICINE
Wyeth Laboratories Philadelphia, Pa.


Could it b
somethin
more thar
growing
old that
"gets her
down"?

Mild mood depression, poor appetite, little interest in the present or future. Does this picture mean that she's giving in to functional fatigue?

When functional fatigue is part of her problem, Alertonic can help counteract accompanying apathy and inertia. It helps lift mood, stimulate appetite, and establish new interest in daily life.

Pleasant-tasting Alertonic combines pipradrol hydrochloride—a gentle cerebral stimulant—with an excellent vitamin and mineral formula, in a satisfying 15% alcohol vehicle.

Especially in the aging patient, nothing fosters confidence and a sense of well-being better than your own personal warmth, understanding, and encouragement. Between visits, however, your prescription for Alertonic can help keep your patient from giving in to functional fatigue.

Adequate dosage is important: Prescribe Alertonic—one tablespoonful t.i.d., 30 minutes before meals ...tastes best chilled.

And for your patient's sake, prescribe Alertonic in the convenient, economical one-pint bottle.

Available only on prescription

Alertonic®

Each 45 cc. (3 tablespoonfuls) contains: alcohol, 15%, pipradrol hydrochloride, 2 mg.; thiamine hydrochloride (vitamin B_1) (10 MDR*), 10 mg.; riboflavin (vitamin B_2) (4 MDR), 5 mg.; pyridoxine hydrochloride (vitamin B_6), 1 mg.; niacinamide (5 MDR), 50 mg.; choline,† 100 mg.; inositol,† 100 mg.; calcium glycerophosphate, 100 mg. (supplies 2% MDR for calcium and for phosphorus) and 1 mg. each of the following:
manganese (as sulfate), magnesium (as acetate), zinc (as acetate), and molybdenum (as ammonium molybdate).

*Multiple of adult Minimum Daily Requirement supplied.
†The need for these substances in human nutrition has not been established.

Indications: 1. Functional fatigue such as that often associated with: a depressing experience or stressful time of life; advancing years; convalescence; limited activity or confinement. 2. Poor appetite and vitamin-mineral deficiency as they occur in: patients having faulty eating habits; geriatric patients who are losing interest in food; patients convalescing from debilitating illness or surgery.

Contraindications: As with other drugs with CNS stimulating action, Alertonic is contraindicated in hyperactive, agitated or severely anxious patients and in chorea or obsessive compulsive states.

Side effects: Reports of overstimulation have been rare. Patients who are known to be unduly sensitive to the effects of stimulant drugs should be observed carefully in the initial stages of treatment.

Dosage: Adults, 1 tablespoonful; children (over 15 years old), 1 to 2 teaspoonfuls; children (4 to 15 years old), 1 teaspoonful. To be taken three times daily 30 minutes before meals.

Merrell

THE WM. S. MERRELL COMPANY
Division of Richardson-Merrell Inc.
Cincinnati, Ohio 45215

7-8378

The Mediatric® Age:

Many patients, with or without a functional illness, show symptom
an aging metabolism: disinterest... lassitude... vague aches and pai

Mediatric® can help them lead a more active, useful l



ndidates for Mediatric

monly heard complaints from your geriatric pa-
may indicate an underlying disorder that may
re immediate attention—and definitive therapy.
with or without an underlying functional illness,
atients' physical and emotional well-being may
nhanced by adjunctive steroid-nutritional ther-
That's why so many patients just like these are
ble candidates for MEDIATRIC from their very
visit.

teroid-nutritional compound (Mediatric) was
in 100 patients to relieve some of the symptoms
ed by degenerative changes of aging.... This
py resulted in improvement of 75 per cent of the
nts...."

eill, A. J.: Clin. Med. *8*:518 (Mar.) 1961.

The estrogen content is PREMARIN® (conjugated estrogens—equine), the orally active, natural estrogen most widely prescribed for its superior physiologic and metabolic benefits. The combination of estrogen and *methyltestosterone* can help maintain an anabolic balance to forestall premature deteriorative changes of aging.

MEDIATRIC also supplies a small amount of *methamphetamine* to provide a gentle mood uplift; and nutritional supplements specially selected to meet the needs of the aging.

MEDIATRIC helps keep the older patients alert and active; helps relieve general malaise, easy fatigability, vague pains in the bones and joints, and lack of interest so often associated with declining gonadal hormone secretion.

RAINDICATION: Carcinoma of the
ate, due to methyltestosterone
onent.

ING: Some patients with pernicious
a may not respond to treatment
he Tablets or Capsules, nor is ces-
of response predictable. Periodic
nations and laboratory studies of
ious anemia patients are essential
ecommended.

FFECTS: In addition to withdrawal bleeding, breast tenderness or hirsutism may occur.

SUGGESTED DOSAGES: **Male and female:** 1 Tablet or Capsule, or 3 teaspoonfuls Liquid, daily or as required.

In the female: To avoid continuous stimulation of breast and uterus, cyclic therapy is recommended (3 week regimen with 1 week rest period—Withdrawal bleeding may occur during this 1 week rest period).

In the male: A careful check should be made on the status of the prostate gland when therapy is given for protracted intervals.

SUPPLIED: No. 752 – MEDIATRIC Tablets, in bottles of 100 and 1,000.

No. 252 – MEDIATRIC Capsules, in bottles of 30, 100, and 1,000.

No. 910 – MEDIATRIC Liquid, in bottles of 16 fluidounces and 1 gallon.

Steroid-nutritional compound	Each MEDIATRIC **TABLET or CAPSULE** contains:	Each 15 cc. (3 teaspoonfuls) of MEDIATRIC **LIQUID** contains:
Conjugated estrogens–equine (PREMARIN®)	0.25 mg.	0.25 mg.
Methyltestosterone	2.5 mg.	2.5 mg.
Methamphetamine HCl	1.0 mg.	1.0 mg.
Cyanocobalamin	2.5 mcg.	1.5 mcg.
Intrinsic factor concentrate	8.0 mg.	–
Thiamine HCl	–	5.0 mg.
Thiamine mononitrate	10.0 mg.	–
Riboflavin	5.0 mg.	–
Niacinamide	50.0 mg.	–
Pyridoxine HCl	3.0 mg.	–
Calcium pantothenate	20.0 mg.	–
Ferrous sulfate exsiccated	30.0 mg.	–
Ascorbic acid	100.0 mg.	–
		(Contains 15% alcohol)

Mediatric® tablets · capsules · liquid

AYERST LABORATORIES • New York, N.Y. 10017 • Montreal, Canada


1 PINT (473 cc.)
M-87
SUSPENSION
CO-PYRONIL
PYRROBUTAMINE COMPOUND
100 No. 336
PULVULES
CO-PYRONIL
PYRROBUTAMINE COMPOUND
No. 342
PULVULES
CO-PYRONIL
PYRROBUTAMINE COMPOUND
Pediatric
Lilly
for
quick relief
that lasts
and lasts
Co-Pyronil®
Pyrrobutamine Compound
Additional information available to physicians upon request. ELI LILLY AND COMPANY, INDIANAPOLIS, INDIANA 46206.
Lilly
706807



President's Address

A Proud Legacy

GEORGE S. PALMER, M.D.

In a first class, effective, well run organization of professionals, pride in accomplishment of objectives and proper execution of individual roles is a deep and basic thing. Our Florida Medical Association is such an organization of physicians ably backed by a superb administrative group of dedicated persons to whom we are all beholden. We are indeed fortunate to have such an efficient and hard-working group in our headquarters to take care of the many and endless details of organization and administration which we physicians could not possibly do ourselves. I want to acknowledge their importance, their contributions and to thank them all from the bottom of my heart. We have the best executive director of them all. He is a gentleman, a friend, adviser and ever faithful associate.

Our FMA has a proud history and legacy. We are indebted to everyone before us, from the founders to our immediate predecessors who have worked so hard and tirelessly in guiding our affairs and pursuing the proper objectives in accomplishing our reason for being.

I will now read to you the address of the President of FMA which was delivered at the 37th annual session on April 6, 1910 in Jacksonville. This is done for personal reasons and also to point out that many problems still remain basically much the same after 57 years. Fortunately, the desires, motivations and goals of our interested, active working members and leaders remain steadfast. The President's address of 1910 follows, and I quote:

> "Gentlemen of the Florida Medical Association:
>
> "The feelings of pride, appreciation and gratitude which were expressed when last year you honored me by election to the presidency of this great Association have abided with me constantly; and now, at the close of our convention year, please permit me to express anew my profound thanks to this body for the signal distinction which its favor has permitted me to enjoy.

President's address, delivered May 11, 1967 at the 93rd Annual Meeting, Americana Hotel, Bal Harbour, Florida.

"For nearly forty years this Association has existed and striven for the betterment of the medical profession in Florida, and in this endeavor it has been both the pioneer and by far the most potent factor; which is equivalent to saying that it has, no less than the preaching of the gospel, been a great and influential agency in the development of the civilization and elevation of the physical and moral condition of the people. In such work none but right-thinking, high-minded and capable men could achieve sure and lasting success, and of such characters the roll of the Florida Medical Association through the years has been full.

"It seems especially fitting that while guests of the Duval County Medical Society our thoughts should revert to the early history of this Association. Duval county has for generations been fortunate in the type of her medical men, and their individual excellence and organized importance and influence have made deep and beneficent impress upon the character and standing of the profession in Florida. It will be remembered that the call for the meeting to organize a State Medical Association was issued by the Duval County Medical Society in 1872, and was signed by such ornaments to the profession as Dr. A. S. Baldwin, Dr. E. T. Sabal, Dr. F. P. Wellford, Dr. R. P. Daniel and others, each of those named having served as president of this organization in years subsequent to its formation in 1873. Of those eminent physicians all have now departed this life leaving blessed memories and cherished examples, save Dr. Daniel, who remains as an inspiration and a model for the younger men of this day.

"Frequently during the history of this Association has it enjoyed the generous hospitality of the Duval County Medical Society. More than that: there have been crises when it seems that only the public spirit and devoted loyalty of men like Dr. Daniel and Dr. Fernandez, our beloved Secretary, have kept our organization intact and alive, an effective force in the affairs of the profession and of the State. In the rush and onward progress of this day it is well to pause occasionally and reflect upon the debt of gratitude which we owe to the capable and earnest men who safely and carefully builded the foundations and piloted the Association through its formative period and years of stress. In that galaxy the speaker may be pardoned for his pride in including a revered kinsman, Dr. T. M. Palmer, of Monticello, Fla., a former president of this Association and for half a century an active and successful physician and surgeon of Middle Florida.

"Returning now to present times and conditions, what is the state of this Association, and what of its future? Beyond a doubt the aims and objects of this body should appeal to the sympathy and the professional pride of every physician of standing in the State, and equally certain is it that in our membership are embraced a large proportion of the leading and most efficient practitioners. Yet our roll is not near as long and comprehensive as it ought by all means to be. Six years ago we had 236 members in 19 counties. The list in 1905 held 204 names from 23 counties. In 1907 there were 304 members from 20 counties. The last edition (1909) of the American Medical Directory showed 786 physicians in the State of Florida, and only 290 of them members of this Association.

"Instead of having only 37 per cent of the physicians of Florida in our membership, we should certainly have not less than 75 per cent. To this end, strong and earnest missionary work is needed, and it ought to be put forth not at some time in the vague future, but right now, without delay. During the coming year no better service can be done for this Association than for each member to recruit at least one new member by the date of our next annual meeting. To do this nothing is needful except to overcome the apathy and lack of appreciation under which nonmember physicians are now laboring. The suggestion that each present member bend his efforts to secure one new member this year is respectfully and earnestly submitted to all gentlemen present and to all the doctors of Florida. This movement, if successful, will give this Association a membership of practically three fourths of the physicians of the State, after which the future will easily take care of itself.

"It should be the pleasure, as it is the duty, of this Association to commend, uphold and aid the splendid work along sanitary and hygienic lines which is being prosecuted by the State Board of Health. In both its laboratory and its field work, that Board is accomplishing results of incalculable benefit to the people of

Florida and to medical science. The entire population is, and should be, proud of the efficiency and usefulness of the State Board of Health, and it is a cause for congratulation that the Board has been granted the greater part of the powers which it has sought from the Legislature, that it has sufficient funds for satisfactory maintenance; and, above all, that it has gained and merited the confidence of the people and the profession in the State.

"It is doubtful if any Southern State has a more efficient or better officered State Board of Health. Its initiative in the hookworm campaign, in the fight against tuberculosis, in bringing its constituents within reach of antitoxins and in the development and extension of the various branches of laboratory work—and its promptness in rising to every emergency—entitle it to the highest praise from every class and profession. Certainly the doctors of the State should stand united at the back of the Board.

"In Florida's open and gracious climate there should be modern, commodious and thoroughly equipped sanitariums for the segregation and treatment of tubercular persons, especially among the poorer classes. To the members of this Association this fact is, of course, self-evident, and needs no argument nor amplification. What is needed, however, is a more concentrated and determined effort on the part of the profession to secure the establishment upon a lasting basis of one or more such sanitariums. In this, as in most other things which are desirable yet difficult of attainment, we never realize what a large measure of success can be achieved until we have actually made a faithful, united effort.

"Another direction in which we owe it to ourselves and the profession to do some effective missionary work is in combating the fallacies widely entertained in some circles and communities concerning vivisection of animals and vaccination of persons. As to the first, it is constantly surprising to know how many good and otherwise enlightened people firmly believe that surgical experiments on dumb animals are invariably and necessarily attended by shocking brutalities; and as to vaccination, it is even far more surprising to realize the extent to which prejudice against this preventive exists. It ought not to be considered undignified or unprofessional for physicians



Dr. George S. Palmer delivers his President's Address to the House of Delegates.

and surgeons to work aggressively and openly towards thwarting the misrepresentations and removing the ignorance upon which such delusions feed and grow.

"Indeed, on all sides are evidences that the legitimate, regular physicians of Florida must take a keener, more concerted interest in the public affairs of the State, or suffer injury to their interests. By this, of course, is not meant the dabbling in ward or factional politics, or seeking political offices for ourselves (which few of us ever want) but the thoughtful and careful crystallization of our matured judgment as a body of physicians upon numerous important questions of public policy, and loyal, persistent effort, collectively and individually, to create public sentiment favorable to the adoption of such views. Prior to the last session of the Florida Legislature, the handful of Osteopaths in the State had gotten together and agreed on a statute which they wanted enacted to give them standing in Florida. There were but few of the Osteopaths, but they had gotten together and they stood shoulder to shoulder in pressing their demands. They got what they wanted. Precisely the same thing was being done in precisely the same way by the handful of Optometrists in the State at the same time.

"All this legislation contained features strongly objectionable to regular physicians and established situations embarrassing to our profession. Yet where were we? Did we present a solid, united front in an endeavor to impress our views upon the Legislature? Just

the contrary. No violence of appeal seemed to have sufficient force to awaken our members to the importance of acting, and practically speaking, the general run of legislators were left to suppose that there was no organized opposition to any part of the Osteopath or the Optometric program, and that, therefore, their statutes were all right and good.

"This Association ought to get together in a firm resolve to achieve some improvements or reforms in the laws of Florida relative to the practice of medicine. The law is glaringly inadequate, first in that it does not define the practice of medicine; second in that there are too many examining boards, with no responsibility nor relation, one to the other. We are in a worse condition than the State Colleges were a few years ago. There ought to be a wholesale abolition of independent Examining Boards and the creation of a Central Board, composed of representatives of the different schools, with a uniform system for granting licenses and uniform regulations for the suppression of abuses."

Pride in one's family should run deep. I am proud of mine. Happily, most of them are here today. I am also proud of my medical heritage and legacy. The address I have quoted was given by my father, Henry Edwards Palmer. He was a wonderful man, a devoted father and a person who loved life and his fellow men to the fullest. He lived and enjoyed each day as it came and he always said that he wanted to "die with his boots on." This he did in his 78th year of a full life after having practiced medicine for 52 years. He was deeply interested in organized medicine and in his FMA. He was faithful in attending all meetings and in doing all that he could for our profession. He was as proud to be our president as I am. The problems 57 years ago were remarkably similar. I must mention my amusement at his suggestion that physicians shouldn't be in politics. He changed his tune completely during the Franklin D. Roosevelt administrations, becoming an ardent and vociferous anti-New Dealer. He would have been 100 years old now. He also would have been extremely proud of our Association, its members, its goals and objectives. He would have been as proud as I am of our officers, our Board of Governors and all of our real workers. And so, in attempting to carry on a family tradition in medicine and in service, I am proud to have been your president. I am prouder still to have been the first son of a former president to serve in this office. I thank you from my heart for giving me this privilege and this high honor. It is second in the memorable events of my life only to that of marriage to my Marie and having our own wonderful family in whom I am so well pleased. May our profession, through our association and its members, continue our steady growth, progress and service. Let us keep the faith and continue our proud legacy.

Proceedings

Ninety-Third Annual Meeting

Florida Medical Association, Inc.

Bal Harbour, Florida, May 11-14, 1967

General Session

Abel Seymour Baldwin Memorial Lecture

The General Session of the Ninety-Third Annual Meeting of the Florida Medical Association was called to order at 11:00 a.m. on Friday, May 12, 1967 in the Grand Ballroom of the Americana Hotel, Bal Harbour, Florida, by President George S. Palmer.

Dr. Russell B. Carson, Chairman of the Scientific Work Committee, presented the awards for scientific exhibits. First prize, the Aesculapius Award of Mead Johnson Laboratories in the amount of $200.00, was awarded to Thomas Herman, M.D. and J. Brown Farrior, M.D., both of Tampa, for their exhibit "Tympanoplasty in 3-D." Second prize, a check for $50.00 from the Florida Medical Association, went to Walter Lane, M.D. and Wayne Lafferty, M.D., both of Temple Terrace, for their exhibit "Office Bacteriology." Third prize, a check for $25.00 from the Florida Medical Association, was given to James R. Jude, M.D., Carlos R. Lombardo, M.D. and Kazi Mobbin-Uddin, M.D., all of Miami, for their exhibit "Techniques in Cardiac Pacing." Four exhibits were given Honorable Mention: "Hemodynamics of Portal Hypertension", by W. Dean Warren, M.D., John J. Fomon, M.D. and Manuel Viamonte Jr., M.D., all of Miami; "Radiation Treatment of Carcinoma of the Cervix," by Mario Vuksanovic, M.D., Ernesto Fonts, M.D. and Mr. Al Hancock, all of Miami; "Pervenous Synchronous Pacemaking," by Cesar A. Castillo, M.D. and Sol Center, M.D., both of Miami Beach, and "Renal Masses—What is Your Diagnosis?" by Luis O. Martinez, M.D., Manuel Viamonte Jr., M.D., Raymond E. Parks, M.D. and Victor Politano, M.D., all of Miami.

Dr. Palmer recognized Mr. Phil Kronen, sales manager for Mead Johnson Laboratories, and thanked him in the name of the Association for the Aesculapius Award donated by his company.

In his introduction of his guest speaker, The Honorable Claude R. Kirk Jr., Governor of Florida, Dr. Palmer demonstrated his ability to combine scholarly research with gentle humor as he



Dr. Thomas Herman accepts the Aesculapius Award from Dr. Russell B. Carson, Chairman of the Scientific Work Committee.

reviewed the history of Florida's first Republican Governor, Harrison Reed, who held the office about 100 years ago, was threatened with impeachment, and whose Lieutenant Governor and Secretary of State tried to take over his office.

Governor Kirk, in a very happy and jovial mood, reported that he had just signed the Disney World legislation and this announcement was received with applause.

The Governor then paid tribute to Dr. Abel Seymour Baldwin by reviewing his great accomplishments as a physician and as a citizen of Florida. He called upon the doctors of today as men of education and ability to use these talents not only in their profession but also by being leaders in their communities and in the state.

At the close of his address, the Governor announced the establishment of a Steering Committee on Health and signed the Executive Order as follows:

WHEREAS, in the field of health it is imperative that the State of Florida provide its people with the finest possible health planning and services, and

WHEREAS, The population is rapidly increasing, and the scope, complexity, and number of programs and amounts of money involved have reached such magnitude as to become one of the major responsibilities of the State Government, and

WHEREAS, The Executive Department of the State is required and expected to provide planning and leadership towards the solution of problems affecting the people of the State, and

WHEREAS, There is an increasing need to secure and take advantage of the best professional advice in connection with problems of health, and

WHEREAS, It has been determined that such advice and consultation can best be secured



Governor Claude R. Kirk Jr.

through the establishment of a group of informed citizens with professional training and experience,

NOW, THEREFORE, I, Claude R. Kirk, Jr., by virtue of the authority vested in me as Governor of the State of Florida do hereby:

1. Establish a STEERING COMMITTEE ON HEALTH within the office of Governor to be composed of citizens with professional training and experience who shall serve at the pleasure of the Governor without compensation to study, make recommendations, and develop guidelines in the areas of:

a. The care of chronically ill and aged indigents.

b. The outpatient care of indigents.



Governor Kirk appoints Dr. Samuel M. Day chairman of the Governor's Steering Committee on Health.

c. The coordination and maximum utilization of state agencies rendering health services.
d. The role of voluntary health agencies operating in Florida.
e. The maximum utilization of personnel trained in the health field.
f. The selection and procurement of medical services-facilities, drugs, and supplies.
g. The health and medical operations of the various state agencies with such programs, and their interrelationships with each other.
h. The evaluation of the education of medical and paramedical personnel including standards, costs, and productivity.
i. Health planning.
j. Any additional areas of study in the health field deemed advisable by the Committee.

2. The Committee shall consist of the following members:

Samuel M. Day, M.D., 415 Medical Arts Building, Jacksonville, Past President of the Florida Medical Association

Jere W. Annis, M.D., 1600 Lakeland Hills Boulevard, Lakeland, Past President of the Florida Medical Association

Irving E. Hall, Jr., M.D., 712 39th Street, W., Bradenton, Member, Board of Governors, Florida Medical Association

Edward J. Haskell, Jr., M.D., 1329 Thomasville Road, Tallahassee, Chairman, Committee on State Legislation, Florida Medical Association

Louis C. Murray, M.D., 60 West Columbia Street, Orlando, Member, Board of Regents, State of Florida

George S. Palmer, M.D., 1204 Miccosukee Road, Tallahassee, President, Florida Medical Association

Mr. C. Shelby Dale, Chairman, Florida Development Commission, Tallahassee

Mr. W. Harold Parham, Post Office Box 2411, Jacksonville, Executive Director, Florida Medical Association

Harold B. Pattishall, Jr., D.D.S., St. James Building, Jacksonville, President-Elect, Florida State Dental Society

Eugene G. Peek, Jr., M.D., Post Office Box 969, Ocala, President, Florida State Board of Health

Warren W. Quillian, M.D., 140 Alhambra Circle, Coral Gables, Member, Board of Trustees, University of Miami

Wilson T. Sowder, M.D., Post Office Box 210, Jacksonville, State Health Officer, Florida State Board of Health

W. Dean Steward, M.D., 32 W. Sturtevant Avenue, Orlando, President-Elect, Florida Medical Association

Mr. Michael J. Wood, 4237 Verona Avenue, Jacksonville, President, Florida Hospital Association

3. Dr. Samuel M. Day is designated as Chairman of the STEERING COMMITTEE ON HEALTH and shall call the members together at a time and place to be selected by him. Mr. W. Harold Parham is designated as Secretary of the Committee. At the organization meeting the STEERING COMMITTEE ON HEALTH shall select those additional officers it considers necessary and shall prepare those by-laws it deems advisable to meet its responsibilities under this Executive Order.

IN TESTIMONY WHEREOF, I have hereunto set my hand and caused the Great Seal of the State of Florida to be affixed at Tallahassee, the Capital, this 12th day of May, A.D., 1967.

CLAUDE R. KIRK, JR.
Governor



Homer Lee Pearson, M.D.
April 12, 1898 — May 10, 1967

Homer Lee Pearson, M. D.
In Memoriam

As it must to all men, death came on the afternoon of May 10, 1967, to our distinguished and beloved member, Homer Lee Pearson, M. D.

After having graduated from Emory University School of Medicine followed by an internship at Piedmont Hospital in Atlanta, Dr. Pearson moved to Miami. His professional interest was in obstetrics and gynecology. His other special interests were, first, his fellow man, second, organized medicine and third, the Riverside Methodist Church. Dr. Pearson's father was a minister and his son is a minister; therefore, little wonder that he became a pillar of strength in his local Methodist church. At his funeral three ministers of that church gave stirring and eloquent eulogies as to the worth and strength of this great doctor to his church and its members.

Homer Pearson will be long remembered by many, many members of the Florida Medical Association for his fatherly, kindly and logical advice in times of stress, need and trouble.

In his first few months of practice, Homer became deeply interested in organized medicine and gave much of his skill and time to the Dade County Medical Association. He was honored by being the only member who has ever been twice elected to the presidency. He originated the Dade County Medical Bulletin and was its editor for many years. Those of us who served in the military forces during World War II will be forever grateful for "Homer's Poop Sheet" whereby he kept all of us informed of the whereabouts and activities of all other members of the Dade County Medical Association in the military services.

The Florida Medical Association early recognized Dr. Pearson's talents and made him its president in 1934. In 1943 he was elected to the House of Delegates of the American Medical Association, a position which he held for many years. In 1948 he was elected to the Judicial Council of the AMA and became its chairman in 1954. He was elected in 1961 to membership on the Board of Trustees of the American Medical Association, an office he held at the time of his passing. Dr. Pearson also served as secretary of the Florida State Board of Medical Examiners since 1950.

A great man in Florida medicine has passed away.

For many, many years the meetings of the Florida Medical Association have been opened by an invocation by Homer and closed by his benediction. It shall come to pass, as it always has and always will, that other members of this Association will give the invocation and other members will pronounce the benediction. But Homer, to those of us who have known you and loved you through these many years, no one will ever take your place; no one will ever fill your shoes. This, Homer, is our benediction.

JOSEPH S. STEWART, M. D.
Miami

Our President

Editor's note: The following editorial appeared in the May 1934 issue of the Journal at the time Dr. Homer L. Pearson assumed the presidency of the Association.

T.M.

Homer Lee Pearson was born in Ware County, Georgia, April 12, 1898, within sight of the dark and dismal horizon which marks one of the seven wonders of America, the great Okefenokee Swamp. His early preparatory work was obtained at Sparks College and at Oxford, Georgia. Graduating from the Emory University School of Medicine in 1921, he completed a course in Public Health work at Augusta, Georgia, and afterward became engaged in this work as Commissioner of Public Health in Thomas County,

Georgia. Realizing that Public Health work was not his métier, he entered Piedmont Hospital in Atlanta, Georgia, where he completed his internship and was afterward engaged in general practice at Clifton, South Carolina, for one year. He then completed a term of post-graduate work at the New York Lying-in and Post-Graduate Hospitals and came to Miami in August, 1924. He is a Mason, a Shriner, and a member of the Phi Beta Pi medical fraternity.

To estimate Homer Pearson from his published literary contributions or from any outstanding professional abilities—would be unfair and unjust. His impress on his profession can be properly evaluated only by those who have enjoyed his care and skill, and by those of his colleagues who have felt the influence of his personality. It is doubtful if any medical man has attained the high position in his profession with which he has been honored, without a greater number of enemies. Homer Pearson possesses a genuine gaiety of spirit, he is a prince of good company, a genial and entertaining companion with a great sense of humor and a personality which has endeared him to the hearts of his colleagues. Yet, his convictions are firm and his sense of obligation to his patients and to his profession is boundless.

There are a few of us who have seen Homer Pearson when "smoke got in his eyes." We found deep down beneath the surface a still deeper sense of religious conviction and a seriousness which is rarely understood.

His most outstanding characteristics, perhaps, are his capacity for work and his intense interest in organized medicine. It is these qualifications which have made him a leader in his community, for

"It is a good thing to remember,
But a better thing to do
He always works with the construction gang
And not with the wrecking crew."

First House of Delegates

The House of Delegates of the Florida Medical Association convened at 9:09 a.m. on Thursday, May 11, 1967 in the Grand Ballroom of the Americana Hotel, Bal Harbour, Florida, with Dr. Franklin J. Evans, Speaker of the House, presiding.

The invocation was pronounced by His Excellency Bishop Coleman Carroll of Miami.

The Speaker welcomed the delegates to the Ninety-Third Annual Meeting and announced the membership of the Credentials Committee: Drs. William W. Thompson, Chairman, Ensor R. Dunsford Jr., Edward C. Burns Jr., and Albert C. Jaslow.

The Chairman of the Credentials Committee, Dr. Thompson, reported a quorum of 203 delegates registered out of a possible 264, and moved that they be seated.

Motion was seconded and carried.

Delegates

ALACHUA—Henry J. Babers Jr., George A. Dell, J. Maxey Dell Jr., Taylor H. Kirby Jr., Walter E. Murphree, Richard P. Schmidt.

BAY—John F. Cluxton, Theodore G. Elchos.

BREVARD—Jack T. Bechtel, Laudie E. McHenry Jr., Lee Rogers Jr., Ben C. Storey, Arthur C. Tedford, Joseph C. Von Thron.

BROWARD—Miles J. Bielek, Russell B. Carson, Gordon B. Carver, Frederick W. Fisher, Anthony C. Galluccio, William C. Hartley, Nat T. McGehee Jr., John R. Mahoney, Ray E. Murphy Jr., Henry D. Perry Jr., Lees M. Schadel Jr., Daniel C. Smith, Robert J. Steinborg, Robert G. Talley, W. Dotson Wells (Absent—Robert H. Pfeifer).

CHARLOTTE—Carl N. Reilly.

CLAY—William A. Mulford.

COLLIER—William J. Bailey.

COLUMBIA—(Absent—Frank E. Adel).

DADE—James L. Anderson, Jerome Benson, Morris H. Blau, Rufus K. Broadaway, Harvey E. Brown Jr., Richard C. Clay, Jack Q. Cleveland, Francis N. Cooke, Vincent P. Corso, DeWitt C. Daughtry, Richard C. Dever, Robert F. Dickey, Donald M. Dooley, Richard M. Fleming, M. Eugene Flipse, Maurice M. Greenfield, Marshall F. Hall, Morton M. Halpern, Henry C. Hardin Jr., James J. Hutson, Albert C. Jaslow, Beverly B. Jones, Walter C. Jones III, Robert B. Katims, David Kirsh, Edward J. Lauth Jr., Donald F. Marion, Leon H. Mims Jr., Charles A. Monnin Jr., Elwin G. Neal, Jean J. Perdue, James C. Pringle Jr., Harold Rand, Daniel L. Seckinger III, Everett Shocket, Thomas W. Skaggs, Chauncey M. Stone Jr., William M. Straight, Charles F. Tate Jr., Scheffel H. Wright, Nelson Zivitz (Absent—William A. Abelove, Julius Alexander, David J. Becker, Martin S. Belle, Manuel L. Carbonell, Lynn J. Carmichael, O. William Davenport, H. Clinton Davis, Joseph H. Davis, Paul S. Jarrett, Matthew A. Larkin, Banning G. Lary, Samuel W. Page Jr., George W. Robertson III, Donald W. Smith).

DESOTO-HARDEE-GLADES—Calvin W. Martin.

DUVAL—Samuel J. Alford Jr., Clyde M. Collins, Ensor R. Dunsford Jr., Thomas S. Edwards, John J. Fisher, A. MacKenzie Manson, Thad Moseley, Harry W. Reinstine r., Wade S. Rizk, C. Burling Roesch, John A. Rush Jr., Irvin C. Schneider, Richard T. Shaar, Wilbur C. Sumner, William A. Van Nortwick, James W. Walker, Jonathan H. Wood.

ESCAMBIA—Howard E. Herring Jr., Frank B. Hodnette, Charles J. Kahn, Julian O. Olsen Jr., William M. C. Wilhoit, Earl G. Wolf.

FRANKLIN-GULF—Joseph P. Hendrix.

GADSDEN-LIBERTY—(Absent—Robert P. C. Whittier).

HIGHLANDS—Donald C. Hartwell.

HILLSBOROUGH—Collin F. Baker Jr., Ernest R. Bourkard, Francis C. Coleman, Richard G. Connar, John C. Fletcher, Linus W. Hewitt, Samuel G. Hibbs, Victor H. Knight Jr., Eugene B. Maxwell, W. Mahon Myers, James N. Patterson, William W. Trice Jr., James A. Winslow Jr., Henry L. Wright Jr.

INDIAN RIVER—Charles C. Flood.

JACKSON-CALHOUN—William F. Brunner.

LAKE—Frederick C. Andrews, J. Basil Hall.

LEE-HENDRY—Carey N. Barry, H. Quillian Jones Sr., Edward W. Salko.

LEON-WAKULLA-JEFFERSON—Edward G. Haskell Jr., Nelson H. Kraeft, Stuart C. Smith, Robert N. Webster.

MADISON—(Absent—Thomas G. Bouland Jr.).

MANATEE—Warren G. Darty, Joseph F. P. Newhall Jr., Millard P. Quillian.

MARION—West Bitzer, Henry L. Harrell.

MONROE—Ralph Herz.

NASSAU—Cecil B. Brewton.

OKALOOSA—William W. Thompson.

ORANGE—Axel W. Anderson III, Louis P. Brady, Jesse W. Castleberry, Norman F. Coulter, Robert W. Curry, Thomas C. Dickinson, Truett H. Frazier, Howard B. Goodrich, Harold W. Johnston, Louis C. Murray, Charles R. Sias, Edward W. Stoner, Miles W. Thomley.

PALM BEACH—Carl E. Andrews, Vernon B. Astler, James F. Cooney, Joseph C. Doane, Tscheng S. Feng, James R. Forlaw, Russell D. D. Hoover, Bernard Kimmel, Bernard F. O'Hara, William H. Proctor, Myrl Spivey.

PASCO-HERNANDO-CITRUS—William H. Hubbard.

PINELLAS—Clyde O. Anderson, Charles E. Aucremann, James C. Fleming, Donald Howie, David S. Hubbell, Charles H. Lasley, Jack A. MaCris, Donald G. Nikolaus, Thomas M. L. Quehl, Peter J. Spoto, Richard C. Trump, Abbott Y. Wilcox Jr., Walter H. Winchester, Rowland E. Wood (Absent—William H. Keeler III).

POLK—Marvin G. Burdette, Edward C. Burns Jr., Paul E. Coury, Howard M. DuBose, John W. Glotfelty, Woods A. Howard, Charles Larsen Jr., Willard B. Manry Jr.

PUTNAM—Fairfax E. Montague.

ST. JOHNS—Joseph A. Shelley.

ST. LUCIE-OKEECHOBEE-MARTIN—John M. Gunsolus, Howard C. McDermid.

SANTA ROSA—(Absent—R. Don Bryan).

SARASOTA—John M. Butcher, Samuel E. Kaplan, Karl R. Rolls, Melvin M. Simmons, Millard B. White.

SEMINOLE—Vann Parker (Absent—Maria P. Perez).

SUWANNEE-HAMILTON-LAFAYETTE—Alex Kish.

TAYLOR—John H. Parker Jr.

VOLUSIA—Michael R. Blais, William E. Carter, Thurman Gillespy Jr., William H. Harrison Jr., Charles L. Rickerd.

WALTON—(Absent—McKinley Cheshire Jr.).

WASHINGTON-HOLMES—Herbert E. Brooks.

COUNCIL ON SPECIALTY MEDICINE—James D. Beeson, Jack H. Bowen, Andre S. Capi, James W. Clower Jr., Charles K. Donegan, Emmet F. Ferguson Jr., David W. Goddard, Sanford A. Mullen, Walter W. Sackett Jr. (Absent—J. Alfred Bowers, Edward W. Cullipher, Marlin C. Moore, Bernard L. N. Morgan, Curtis G. Rorebeck, Thomas E. Scott Jr.).

DELEGATES TO A.M.A.—Jere W. Annis, Reuben B. Chrisman Jr., Burns A. Dobbins Jr., Francis T. Holland, Robert E. Zellner.

PAST PRESIDENT A.M.A.—(Absent—Edward R. Annis).

OFFICERS—James T. Cook, William J. Dean, Franklin J. Evans, H. Phillip Hampton, Floyd K. Hurt, George S. Palmer, W. Dean Steward.

BOARD OF PAST PRESIDENTS—Jere W. Annis, Samuel M. Day, H. Phillip Hampton, Ralph W. Jack, Edward Jelks, Walter C. Jones, Francis H. Langley, Duncan T. McEwan, John D. Milton, Eugene G. Peek Sr., Warren W. Quillian, William C. Roberts, Joseph S. Stewart, Leo M. Wachtel, Robert E. Zellner (Absent—Orion O. Feaster, Frederick K. Herpel, Robert B. McIver, Walter C. Payne Sr., William M. Rowlett, William C. Thomas Sr.).

Motion was carried to approve the order of business as printed in the Handbook.

The Speaker asked for approval of the minutes of the Ninety-Second Annual Meeting as published in the July 1966 issue of the Journal of the Florida Medical Association.

Dr. Edward J. Lauth Jr., Dade, asked for correction of Recommendation No. 4 of the Council on Medical Services, page 605 of the July Journal, which read:

> "That a revised abortion law utilizing principles approved in a model law by the American Bar Association and the American Medical Association be introduced in the 1967 session of the Florida Legislature."

Dr. Lauth said that the American Medical Association had never approved this model law and moved that the words "and the American Medical Association" be stricken from this recommendation.

Motion was carried to approve the minutes as corrected.

The Speaker asked the House to grant a momentary divergence from the order of business for a very sad announcement by Past President Joseph S. Stewart.

Dr. Stewart: "Mr. Speaker, Ladies and Gentlemen:

"I bring you the sad news of the death of a beloved member. Yesterday afternoon at his home in Miami, Dr. Homer L. Pearson passed away; at ease at long last from the ravages of that dread disease, cancer.

"Dr. Pearson was not an ordinary member of this association. Indeed, he has been an integral part of organized medicine in Florida for over 40 years. First, he made his name with his local county society. He was the only member ever elected to two terms as president. He originated the Dade County Medical Bulletin and was its editor for many years. His state association then called upon him and gave him all the honors it could bestow. He was its president in 1934. He was elected delegate to the American Medical Association, and there his judicial temperament, his great kindness and his keen insight into the problems of the doctor and the patient were recognized and he was elected to the Judicial Council, where he served for many years, and he was then elected to the Board of Trustees of the American Medical Association.

"For many, many years the meetings of this association have been opened by an invocation by Dr. Pearson and closed by his benediction. It shall come to pass, as it always has and always will, that other members of this association will give the invocation and other members will pronounce the benediction. But, Homer, to those of us who have known you and loved you through these many years, no one will ever take your place; no one will ever fill your shoes. This, Homer, is our benediction.

"It is my sincere hope that as a tribute to Homer, we will each offer our prayers, not for Homer, but rather as he would have it, to our God that he will give us the knowledge and ability to find a cure for this dread disease, cancer, which has taken our beloved member from us.

"May we request a moment of silent prayer."

The House stood in reverence and prayer.

The Speaker introduced the officers of the Association: Dr. James T. Cook, Vice Speaker; Dr. George S. Palmer, President; Dr. W. Dean Steward, President-Elect; Dr. William J. Dean, Vice President; Dr. Floyd K. Hurt, Secretary-Treasurer, and Mr. W. Harold Parham, Executive Director.

The Speaker then instructed the House:

Remarks of the Speaker

Mr. President, Fellow Delegates, Ladies and Gentlemen:

In the order of business, the program affords the Speaker an opportunity to address this House, and for this privilege I am grateful.

It has been noted before and is worthy of recognition again that since the introduction of a Speaker to conduct the business portion of the annual meeting, the business of the Association has been disposed of with dispatch in a clear and orderly fashion. While this may be due in small part to the efficiency and know-how of your several Speakers over the years, I am more inclined to give the greater portion of credit to this House of Delegates which has readily accepted this guidance and has been most cooperative and responsive to the rules of parliamentary procedure.

In this spirit of helpfulness, let me remind you that our Reference Committees will meet this afternoon and it is before these Committees that any member of FMA may speak freely and frankly on any report or resolution in which he may be interested. Please remember that a resolution before a Reference Committee must have a sponsor; otherwise, it will not be considered.

At the second business meeting of the House, once again every Delegate who so desires it will be afforded an opportunity to express his feelings, being considerate only of the limits of time. Your Speakers ask that upon recognition by the Chair, a Delegate address his comments into a microphone, stating his name and county before proceeding. Please be responsive to rulings of the Chair, so that the meeting may proceed in an orderly fashion. You have the privilege, nay, the right, to be heard, and I hope each Delegate's remarks will be given the proper respect and consideration. None of us has a monopoly on wisdom. None has the perfect solution to all the problems. When the discussion is ended and a vote taken, I hope that each of us will accept the decision of the majority (or 2/3, as the case may be) as the representative sentiment of this House. But this one word of caution. Quoting from the remarks of the Speaker of the House of Delegates of the AMA at the 1966 meeting in Chicago, Dr. Milford O. Rouse, now President-Elect of the AMA, "In the fervor of our zeal, may we never say in public words which can be misinterpreted by those who may have ulterior motives."

I, personally, have implicit confidence in the sincerity and integrity of every member of this House.

And now, to quote Dr. Rouse again, back to our work in the best tradition of American medicine.

The Speaker called attention to the blanket accident insurance provided for all those attending the meeting on official business, and reminded the House that all supplemental reports must be in writing, with the exception of the supplemental report of the Committee on State Legislation, which would be given orally.

Three distinguished guests were introduced: Mrs. Allen E. Kuester, President, and Mrs. Russell B. Carson, President-Elect, of the Woman's Auxiliary to the Florida Medical Association, and Mrs. Asher Yaguda, President of the Woman's Auxiliary to the American Medical Association.

The ladies were escorted to the podium by Dr. Lee Rogers Jr.

Mrs. Kuester spoke briefly on the objectives and accomplishments of the Woman's Auxiliary.

Mrs. Yaguda brought greetings from the National organization, reviewed some of its activities and highly complimented the Florida Auxiliary for its accomplishments.

The Honorable William P. Simmons Jr., President-Elect of The Florida Bar, was introduced.

Mr. Simmons brought greetings from the 10,000 members of The Florida Bar and discussed briefly programs of mutual interest to the two organizations—the Florida Professional Council, specialization and professional liability. He stated that The Florida Bar approved the legislative aims of the Florida Medical Association and hoped they were successful in having them passed. He also asked the support of the Florida Medical Association in the Bar's main objectives —the improvement of Florida's judicial system and the adoption of a new Constitution.

Dr. Palmer took the Chair and asked Dr. J. Maxey Dell Jr. to escort Dr. Walter E. Murphree of Gainesville to the rostrum. He then presented to Dr. Murphree the A. H. Robins Company "Annual Award for Outstanding Community Service by a Physician."

A. H. Robins Company Award

"For Outstanding Community Service by a Physician"

Dr. Walter Ellis Murphree of Gainesville is the recipient of the 1967 Community Service Award of the A. H. Robins Company. Annually this signal honor is accorded a member of the Florida Medical Association who has rendered distinguished service in civic and community activities. The Association's Board of Governors makes the choice from candidates nominated by the component medical societies.



Dr. George S. Palmer, President, presents the A. H. Robins Community Service Award to Dr. Walter E. Murphree of Gainesville.

Dr. Murphree was born in Gadsden, Alabama on September 16, 1909. He received a Bachelor of Science degree from the University of Florida in 1930 and a Doctor of Medicine degree from Tulane University in 1934. Dr. Murphree served his internship and residency at Duval County Hospital, Jacksonville. From 1936 to 1940 he was the State Prison Physician, Raiford, Florida. In 1940 Dr. Murphree started the private practice of medicine in Gainesville, where he has practiced since.

During the war years, Dr. Murphree served with the U.S. Army Medical Corps as Assistant Chief of Surgery, Camp Blanding Station Hospital, Florida, and attained the rank of Major.

During his 31 years of practice, Dr. Murphree has been active in community and medical life and has made tremendous contributions in all aspects of both civic and medical life in Gainesville and Alachua County. Dr. Murphree has served his county medical society as president, as chairman of various committees and as a delegate to the Florida Medical Association Annual Meeting. He has served the Florida Medical Association as Vice President from 1955 to 1956 and from 1957 to 1958, as chairman of the Liaison Committee in 1957 and has served on the Board of Governors.

Always interested in the welfare of the community in which he lives and practices, Dr. Murphree has served as a member of the Gainesville City Commission from 1955 to 1961; as Mayor-Commissioner of Gainesville from 1957 to 1958, and as a member of the Citizen's Advisory Committee to the Gainesville City Commission from 1961 to the present.

The dedication of this man is untiring and his accomplishments legion. He has been president of the Florida Association of General Practitioners; a member of the Advisory Committee to the Alachua County Health Department, which founded Gainesville's local health department; a PTA participant, elementary through secondary grades; member, treasurer and merit badge examiner for the Boy Scout program of his church; a vestryman and member of the Episcopal church choir; instructor of life saving and first aid to city utility department employees; a member of the Gainesville Kiwanis Club for 20 years, serving on various committees and having sat on that organization's Board of Directors; an examiner of Little League through high school athletes and a high school team physician, he helped to organize, was a charter member and first vice president of Gainesville's High School Quarterback Club.

Dr. Murphree is married to the former Catherine Hodges of Tallahassee and they have two children, Mary Catherine and Walter Ellis Jr.

Dr. Murphree: "I hoped this award was to be received in silence, but now I find I am supposed to say something.

"Thank you very much, I appreciate this. With a word of explanation, I have always felt that anyone who has been graced with the education that we have should contribute more than just to the profession itself; that we should all contribute to the communities in which we live. It is the community which supports us and it is incumbent upon us to serve the community."

Dr. Murphree then asked his wife, who had assisted him in receiving this award, to stand and be recognized.

The Speaker announced the personnel of Reference Committees and times and places of their meetings as follows:

I. Health and Education
Richard M. Fleming, Chairman
Sanford A. Mullen
Richard G. Connar
William H. Proctor
Albert C. Jaslow

II. Public Policy
Abbott Y. Wilcox Jr., Chairman
James W. Walker
John C. Fletcher
Lee Rogers Jr.
Richard C. Clay

III. Finance and Administration
Robert E. Zellner, Chairman
Nelson H. Kraeft
H. Quillian Jones Sr.
Michael R. Blais
William M. Straight

IV. Legislation and Miscellaneous
Russell B. Carson, Chairman
J. Maxey Dell Jr.
Charles Larsen Jr.
Vernon B. Astler
Maurice M. Greenfield

Meetings:

I. 2:00 p.m. Health and Education — Barbados Room

II. 2:00 p.m. Public Policy — Bermuda Room

III. 2:00 p.m. Finance and Administration— Pan American Room

IV. 2:00 p.m. Legislation and Miscellaneous — Grand Ballroom

The Speaker introduced the President, Dr. George S. Palmer, who gave his presidential address.

Before beginning his address, Dr. Palmer asked all Past Presidents to stand and be recognized.

Dr. Palmer complimented the staff of the Executive Office and expressed appreciation to all of them.

(The complete text of President Palmer's address begins on page 643).

At the close of his address, Dr. Palmer introduced the members of his family who were present: Mrs. Ben Manhoff of Jacksonville; Mr. and Mrs. Julian Proctor of Tallahassee; Mr. and Mrs. Bryan Palmer of Tallahassee; Dr. and Mrs. Thomas Palmer of Jacksonville; Mr. and Mrs. Henry Palmer Jr. and their sons, Henry and Bryan; Dr. Martin Palmer of New Orleans; Mr. and Mrs. George F. Palmer Jr., his three daughters, Park, Lucille and Bridget and his wife, Marie.

At the end of his address, the House gave Dr. Palmer a standing ovation.

Dr. Evans announced that the five resolutions which were submitted the previous day had finally arrived from the printer and were being distributed to all members of the House. He then assigned resolutions 67-39, 67-40 and 67-41 to Reference Committee No. IV and resolutions 67-42 and 67-43 to Reference Committee No. II.

The Speaker announced that the awards of the Certificate of Merit and the Certificate of Appreciation would be made at the Second House of Delegates on Sunday.

Dr. Evans asked for supplemental reports and recognized Dr. William M. Straight, Chairman, Committee on Archives.

Dr. Straight: "Mr. Speaker, Fellow Physicians and Guests:

"At this moment of the first meeting of the House of Delegates, we would like those members of the Florida Medical Association who joined between 1932 and 1935, inclusive, to stand and be recognized. We have affixed to their convention badges a ribbon in honor of this event and will hold a reception on Friday, May 12, in rooms 204 and 205 at 5:00 p.m., which we hope they all will attend.

"For the next few moments, we ask your reverent contemplation of our colleagues and friends who have departed during the past year. Among their names which are in your delegates' packets, you will find that of one past president, Dr. Frederick J. Waas of Jacksonville. In addition, you have just heard of the death of Dr. Homer Pearson through Dr. Stewart's resolution. Homer was a fine example of a physician who labored long and hard for the highest ideals of our profession. In this sad moment, let us recall the words of Robert Louis Stevenson:

> He is not dead, this friend; not dead,
> But, in the path we mortals tread,
> Got some few, trifling steps ahead,
> And nearer to the end;
> So that you, too, once past the bend,
> Shall meet again, as face to face this friend
> You fancy dead.

"Mr. Speaker, I move that this body stand in a moment of silent contemplation in commemoration of our departed colleagues."

The House stood in silent reverence.

The Speaker announced that this supplemental report of the Committee on Archives would be referred to Reference Committee No. III.

Dr. Edward G. Haskell Jr., Chairman of the Committee on State Legislation, gave an oral report on the current status of legislation which is sponsored by FMA, that which is supported by FMA and that which is opposed by FMA, through Wednesday, May 10 at 6:00 p.m.

Dr. Haskell praised the cooperation of members in coming to the Legislature to work both in hearings and in the dispensary.

The Speaker referred Dr. Haskell's supplementary report to Reference Committee No. IV.

The Speaker announced that the Blue Shield Annual Meeting would be held immediately following adjournment of the House of Delegates; that on Friday, May 12, at 11:00 a.m. The Honorable Claude Kirk, Governor of Florida, would appear as the President's guest speaker, and on Friday at 12:30 p.m. there would be a joint FLAMPAC and Woman's Auxiliary luncheon.

Dr. Lauth, Dade, rose to ask that his name be added as joint author of Resolution 67-40 with Dr. Matthew Larkin. The Speaker agreed that this could be done.

Dr. Howard Goodrich, Orange, asked to introduce a resolution regarding the implementation of Title XIX which was passed at a caucus of Orange County delegates on Monday evening. At the request of the Speaker, he read the resolution.

The Speaker ruled that this was not of an emergency nature since several similar resolutions had already been introduced and advised Dr. Goodrich that he could appear before the Reference Committee to present any additional points mentioned in this resolution.

Dr. Scheffel Wright, Dade, rose to announce that Dr. James Feffer, president of the American Society of Internal Medicine, would speak at the meeting of the Florida Society of Internal Medicine on Friday on the subject "Medicare—One Year Later."

Dr. Haskell introduced two members of the Legislature, Dr. John J. Fisher of Jacksonville and Dr. Walter Sackett of Miami.

The Speaker introduced Dr. Wilson T. Sowder, State Health Officer.

Dr. Evans announced the final tally of delegates seated as 230 out of a possible 264.

The House of Delegates recessed at 10:45 a.m. to reconvene on Sunday, May 14, 1967 at 9:00 a.m.

93rd Annual Meeting



President's Reception

PULSE



Fishing Tournament





Art Exhibit

BEAT





Above—Past President's Breakfast

Left—Exhibit Hall

Below—Socio-Economic Panel



Second House of Delegates

The House of Delegates reconvened at 9:15 a.m. on Sunday, May 14, 1967, in the Bal Masque-Medallion Room of the Americana Hotel, Bal Harbour, with Dr. Franklin J. Evans, Speaker of the House, presiding.

Dr. William W. Thompson, Chairman of the Credentials Committee, reported 233 delegates registered, constituting a quorum, and moved that they be seated.

Motion was seconded and carried.

Delegates

ALACHUA—Henry J. Babers Jr., George A. Dell, J. Maxey Dell Jr., Taylor H. Kirby Jr. (Absent—Walter E. Murphree, Richard P. Schmidt).

BAY—Theodore G. Elchos (Absent—John F. Cluxton).

BREVARD—Jack T. Bechtel, Lee Rogers Jr., Arthur C. Tedford, Joseph C. Von Thron (Absent—Laudie E. McHenry Jr., Ben C. Storey).

BROWARD—Miles J. Bielek, Russell B. Carson, Frederick W. Fisher, Anthony C. Galluccio, William C. Hartley, Ray E. Murphy Jr., Henry D. Perry Jr., Lees M. Schadel Jr., Daniel C. Smith, Robert J. Steinborg, Robert G. Talley, W. Dotson Wells, Scottie Wilson (Absent—Gordon B. Carver, Nat T. McGehee Jr., John R. Mahoney).

CHARLOTTE—Carl N. Reilly.

CLAY—William A. Mulford.

COLLIER—William J. Bailey.

COLUMBIA—(Absent—Frank E. Adel).

DADE—James L. Anderson, Pedro Arroyo Jr., William G. Aten, George S. Baldry, David J. Becker, Jerome Benson, Morris H. Blau, Rufus K. Broadaway, Harvey E. Brown Jr., Richard C. Clay, Jack Q. Cleveland, Francis N. Cooke, Vincent P. Corso, DeWitt C. Daughtry, O. William Davenport, H. Clinton Davis, Joseph H. Davis, Richard C. Dever, Robert F. Dickey, Donald M. Dooley, Richard M. Fleming, M. Eugene Flipse, Thomas O. Gentsch, Maurice M. Greenfield, Julian H. Groff, Marshall F. Hall, Morton M. Halpern, Henry C. Hardin Jr., James W. Holmes, Caroline B. Hunter, James J. Hutson, Marvin L. Jaffee, Albert C. Jaslow, Paul S. Jarrett, Beverly B. Jones, Walter C. Jones III, Robert B. Katims, David Kirsh, Banning G. Lary, Edward J. Lauth Jr., Albert W. McCorkle, Donald F. Marion, Leon H. Mims Jr., Charles A. Monnin Jr., Edwin G. Neal, Jean J. Perdue, Harold Rand, Daniel L. Seckinger II, Everett Shocket, Thomas W. Skaggs, Chauncey M. Stone Jr., William M. Straight, Charles F. Tate Jr., Scheffel H. Wright, Nelson Zivitz (Absent—James C. Pringle Jr.).

DESOTO-HARDEE-GLADES—Calvin W. Martin.

DUVAL—Samuel J. Alford Jr., Clyde M. Collins, Ensor R. Dunsford Jr., Thomas S. Edwards, John J. Fisher, A. MacKenzie Manson, Thad Moseley, Harry W. Reinstine Jr., Wade S. Rizk, C. Burling Roesch, John A. Rush Jr., Irving C. Schneider, Richard T. Shaar, William A. Van Nortwick, Jonathan H. Wood (Absent—Wilbur C. Sumner, James W. Walker).

ESCAMBIA—Howard E. Herring Jr., Frank B. Hodnette, Charles J. Kahn, Julian O. Olsen Jr., William M. C. Wilhoit, Earl G. Wolf.

FRANKLIN-GULF—Joseph P. Hendrix.

GADSDEN-LIBERTY—Robert P. C. Whittier.

HIGHLANDS—Donald C. Hartwell.

HILLSBOROUGH—Collin F. Baker Jr., Ernest R. Bourkard, Francis C. Coleman, John C. Fletcher, Linus W. Hewitt, Samuel G. Hibbs, Victor H. Knight Jr., Eugene B. Maxwell, W. Mahon Myers, James N. Patterson, William W. Trice Jr., James A. Winslow Jr., Henry L. Wright Jr. (Absent—Richard G. Connar).

INDIAN RIVER—Charles C. Flood.

JACKSON-CALHOUN—William F. Brunner.

LAKE—Frederick C. Andrews, J. Basil Hall.

LEE-HENDRY—Carey N. Barry, H. Quillian Jones Sr., Edward W. Salko.



LEON-WAKULLA-JEFFERSON—Edward G. Haskell Jr., Nelson H. Kraeft, Stuart C. Smith, Robert N. Webster.

MADISON—(Absent—Thomas G. Bouland Jr.).

MANATEE—Warren G. Darty, Joseph F. P. Newhall Jr., Millard P. Quillian.

MARION—West Bitzer, Henry L. Harrell.

MONROE—Ralph Herz.

NASSAU—Cecil B. Brewton.

OKALOOSA—William W. Thompson.

ORANGE—Axel W. Anderson III, Louis P. Brady, Jesse W. Castleberry, Norman F. Coulter, Robert W. Curry, Truett H. Frazier, Howard B. Goodrich, Harold W. Johnston, Louis C. Murray, Charles R. Sias, Edward W. Stoner, Miles W. Thomley (Absent—Thomas C. Dickinson).

PALM BEACH—Carl E. Andrews, Vernon B. Astler, James F. Cooney, Joseph C. Doane, Tscheng S. Feng, James R. Forlaw, Russell D. D. Hoover, Bernard Kimmel, Bernard F. O'Hara, William H. Proctor, Myrl Spivey.

PASCO-HERNANDO-CITRUS—William H. Hubbard.

PINELLAS—Clyde O. Anderson, Charles E. Aucremann, Ira C. Evans, James C. Fleming, Donald Howie, David S. Hubbell, Charles H. Lasley, Jack A. MaCris, Donald G. Nikolaus, Thomas M. L. Quehl, Peter J. Spoto, Richard C. Trump, Abbott Y. Wilcox Jr., Walter H. Winchester, Rowland E. Wood.

POLK—Marvin G. Burdette, Edward C. Burns Jr., Paul E. Coury, Howard M. DuBose, John W. Glotfelty, Woods A. Howard, Charles Larsen Jr., Willard B. Manry Jr.

PUTMAN—(Absent—Fairfax E. Montague).

ST. JOHNS—Joseph A. Shelley.

ST. LUCIE-OKEECHOBEE-MARTIN—John M. Gunsolus, Howard C. McDermid.

SANTA ROSA—(Absent—R. Don Bryan).

SARASOTA—John M. Butcher, Samuel E. Kaplan, Karl R. Rolls, Melvin M. Simmons, Millard B. White.

SEMINOLE—Vann Parker (Absent— Maria P. Perez).

SUWANNEE-HAMILTON-LAFAYETTE — (Absent — Alex Kish).

TAYLOR—John H. Parker Jr.

VOLUSIA—Michael R. Blais, William E. Carter, Thurman Gillespy, Jr., William H. Harrison Jr. (Absent—Charles L. Rickerd).

WALTON—McKinley Cheshire Jr.

WASHINGTON-HOLMES—Herbert E. Brooks.

COUNCIL ON SPECIALTY MEDICINE—James D. Beeson, Jack H. Bowen, Andre S. Capi, James W. Clower Jr., Charles K. Donegan, Emmet F. Ferguson Jr., David W. Goddard, Sanford A. Mullen, Walter W. Sackett Jr. (Absent—J. Alfred Bowers, Edward W. Cullipher, Marlin C. Moore, Bernard L. N. Morgan, Curtis G. Rorebeck, Thomas E. Scott Jr.)

DELEGATES TO A.M.A.—Jere W. Annis, Burns A. Dobbins Jr., Francis T. Holland, Robert E. Zellner (Absent—Reuben B. Chrisman).

PAST PRESIDENT A.M.A.—Edward R. Annis.

OFFICERS—James T. Cook, William J. Dean, Franklin J. Evans, H. Phillip Hampton, Floyd K. Hurt, George S. Palmer, W. Dean Steward.



Dr. George S. Palmer, President, presents AMA-ERF checks to Drs. Hayden C. Nicholson and William C. Ruffin representing the University of Miami School of Medicine and the University of Florida College of Medicine, respectively.

BOARD OF PAST PRESIDENTS—Jere W. Annis, Samuel M. Day, H. Phillip Hampton, Ralph W. Jack, Walter C. Jones, Francis H. Langley, John D. Milton, Eugene G. Peek Sr., Warren W. Quillian, William C. Roberts, Leo M. Wachtel, Robert E. Zellner—(Absent—Orion O. Feaster, Frederick K. Herpel, Edward Jelks, Duncan T. McEwan, Robert B. McIver, Walter C. Payne Sr., William M. Rowlett, Joseph S. Stewart, William C. Thomas Sr.).

The Speaker recognized guests from allied professions: Dr. Harold B. Pattishall Jr., President, Florida State Dental Society; Mrs. Wava D. Hartsel, R.N., President, Florida Nurses Association; Mrs. Helen Hill James, L.P.N., President, Licensed Practical Nurses Association of Florida; Mr. Millard L. Berman, Past Vice President, Florida Chapter American Physical Therapy Association; Mrs. Rose Merino, Florida Medical Assistants Association, and Mr. N. M. Brinson III, President, Florida Society of Medical Technologists.

Dr. Palmer presented to Dr. Hayden C. Nicholson, Dean of the University of Miami School of Medicine, a check in the amount of $4,395.38 from the American Medical Association Education and Research Foundation, which is a contribution free of all restrictions as to use. Another check in the amount of $4,444.38 from the same source was presented to Dr. William C. Ruffin Jr. of the University of Florida College of Medicine.

Report of Reference Committee No. 1

Health and Education

Dr. Richard M. Fleming, Chairman: "Mr. Speaker, Mr. President and Members of the House of Delegates.

"Your Reference Committee on Health and Education has considered each of the items referred to it and submits the following report. The Committee's recommendation on each item will be submitted separately and we request that each item be acted upon separately before proceeding to the next.

"The Reference Committee considered the report of the Council on Medical Education and Hospitals on page 17 of the Handbook and recommends that it be approved with the following amendment to Recommendation No. 3 at the top of page 18:

"3. That the Florida Medical Association approve the establishment of a third Florida medical school to be located at the University of South Florida in Tampa, and that the Florida Legislature be urged to appropriate necessary funds for immediate planning and construction of the same.

"That the Florida Medical Association offer their help to the University of South Florida during the planning phase of the new medical school and request that the University of South Florida keep the Florida Medical Association informed of the progress of the new medical school.

"Mr. Speaker, I move adoption of this portion of the report as amended."

Dr. William M. Straight, of Dade: "I would like to add an amendment, 'That the Florida Medical Association urge the Legislature to more vigorously support the University of Miami School of Medicine, financially and otherwise."

Amendment was seconded and carried.

Motion as amended was carried.

Council on Medical Education and Hospitals

DAVID W. MARTIN, *Chairman*

Council:

The Council has met on three occasions during the past year. At the first meeting in September, the activities of the past were discussed and a philosophy which embodied a more active role in all phases of medical education with the Council attempting to coordinate all institutions, agencies and groups interested in graduate and post-graduate medical education was adopted. As a result of this meeting, recommendations were made to the Board of Governors and subsequently approved that:



Members of Reference Committee I were Drs. Richard M. Fleming, chm., Sanford A. Mullen, Richard G. Connar, William H. Proctor and Albert C. Jaslow.

1. . . . the Internship brochures sent to senior medical students be discontinued;
2. . . . that contact be maintained with the State Legislative Committee and cooperation be provided to facilitate the resolutions to increase the number of medical students at the University of Miami School of Medicine and the University of Florida College of Medicine;
3. . . . plans were presented for the F.M.A. to sponsor a joint meeting of the entire committee membership of the Council with the Directors of Medical Education of the State, members of the Ad Hoc Committee for General Practice and representatives of the Medical Schools. This meeting was held December 11, 1966, in Orlando, was well attended, and initiated a new relationship of cooperation between the Council, the Directors of Medical Education, and the Medical Schools. A request for written suggestions as a result of this meeting was productive of many excellent ideas which were considered by the Council meeting January 2, 1967, in West Palm Beach.

Reorganization of the Council to include the Committee on Post-Graduate Education and eliminate the Committees on Physician Placement and Hospitals was made to the Board of Governors to be part of its proposed reorganization of Councils.

The Directors of Medical Education throughout the State feel a need to strengthen the internship and residency program and through the Council, the aid of the medical schools has been secured in a collaborative effort. A meeting of Directors of Medical Education with Dr. Hayden Nicholson, Vice President for Medical Affairs of the University of Miami, and Dr. Emanuel Suter, Dean of the University of Florida College of Medicine, was held March 11, 1967, at which time plans were made to study all educational resources of the state in hospital programs.

Recommendations:

1. That the Council continue to take an active part in all phases of medical education and make

every effort to assist in coordinating the activities of all institutions and agencies, particularly those involved in continuing education of physicians.

2. That the Florida Medical Association accept responsibility for planning, implementing and financing of the continuing education of its members, as well as strengthening of graduate training programs.

In a joint meeting with the Committee on Medical Schools held April 1, 1967, the Council on Medical Education and Hospitals after careful and thorough consideration adopted the following recommendation:

3. That the Florida Medical Association approve the establishment of a third Florida medical school to be located at the University of South Florida in Tampa, and that the Florida Legislature be urged to appropriate necessary funds for immediate planning and construction of the same.

That the Florida Medical Association offer their help to the University of South Florida during the planning phase of the new medical school and request that the University of South Florida keep the Florida Medical Association informed of the progress of the new medical school.

That the Florida Medical Association urge the Legislature to more vigorously support the University of Miami School of Medicine, financially and otherwise.

Dr. Fleming: "The Reference Committee considered the report of the Scientific Council and recommends that it be approved as printed in the Handbook.

"Mr. Speaker, I move the adoption of this portion of the report."

Motion seconded and carried.

Scientific Council

RICHARD C. DEVER, *Chairman*

Council:

During the period covered by this report, the Scientific Council held one formal meeting in Jacksonville January 14, 1967. In that the major portion of the Council's activities is carried out by its various committees, additional council meetings were unnecessary.

In the scientific area, the 1966-67 Association year has been one of both study and implementation, as the following brief summaries by fields of responsibility will demonstrate.

Perhaps the most important matter of concern to the Council during the past year was the splintering of the Association's efforts in post-graduate medical education brought about by two councils having responsibilities in this essential field. It is hoped that this organizational problem will be corrected by amendments to the Association's by-laws being submitted by the Board of Governors.

Because all recommendations of the Council and its committees previously were submitted to and acted upon by the Board of Governors, there are no new formal recommendations included in this report.

Scientific Publications—The modernization and expansion program initiated by the Journal in 1965 has been continued. Its results have been reflected by increased scientific and non-scientific contributions by Association members and by increased advertising revenue. To provide variety, special issues featuring Florida medical history and research at the medical schools have been published. Several such future issues are planned and scheduled. New departments have been created for service and interest to readers. All of these changes and improvements have the objective of establishing and keeping the Journal as the prime source of state medical information and stimulation for Florida's physicians.

Annual Meeting Scientific Program—Beginning immediately following the 1966 Annual Meeting, the Committee on Scientific Work held a series of meetings in various parts of the state to plan and perfect the 1967 Annual Meeting scientific program. The program will consist of a morning session devoted to eight carefully selected presentations by Florida physicians, an afternoon session consisting of panel discussions on liver disease and hypertension with panelists chosen from throughout the country, and 19 scientific exhibits. A record number of applications for papers and exbibits was received, which afforded the committee considerable latitude for selection. Another notable achievement of the committee this year was an up-dating of the Association's policy for expense reimbursement of invited guest speakers. Aside from the scientific area, the committee also developed a special socio-economic program which will be presented during the 1967 Annual Meeting.

Postgraduate Education—In the fall of 1966, the Committee on Postgraduate Education surveyed Florida's county medical societies to determine their current activities and future needs in postgraduate education. A majority favored touring faculty groups for short-term seminars requested by individual medical societies or a combination of societies. The committee is studying, in cooperation with the medical schools, the uses of scrambled or closed circuit television and videotapes. It has been deeply concerned with the overlapping of responsibilities for postgraduate activities within the Association referred to earlier in this report, and anticipates much improved future coordination and implementation if appropriate structural revisions are brought about by the 1967 House of Delegates.

Research—The Committee on Research has continued to serve the Florida Medical Foundation by screening and evaluating research projects financed by Foundation grants. In order to provide better reporting to the profession of results of these projects, the committee recommended to the Council that grant recipients be required to submit such reports for appropriate publication and placement in the Association's archives. This recommendation was approved by the Council and by the board of directors of the Foundation.

Dr. Fleming: "The Reference Committee considered the report of the Council on Specialty Medicine and recommends that it be approved as printed in the Handbook.

"Mr. Speaker, I move the adoption of this portion of the report."

Motion seconded and carried.

Council on Specialty Medicine

EDWARD W. CULLIPHER, *Chairman*

Council:

The Council on Specialty Medicine at the time of its October 30, 1966 meeting, considered the following items with resulting actions and recommendations, which are herewith submitted for consideration and approval by the Board of Governors.

Recommendations:

1) Specialty Group recommendations regarding Relative Values.—That each Specialty Group provide,

at the earliest possible date, any additional recommendations for revision of the relative value studies and that the development of their recommendations for revision and adjustment of the Relative Value inequities.

2) Florida Society of Internal Medicine concern re: Blue Shield Complementary Coverage.—That the Council on Specialty Medicine approve in principle the recommendations presented by the Florida Society of Internal Medicine to the effect that Blue Cross-Blue Shield review and revise the Complementary Coverage policy so as to encourage outpatient office care in lieu of continuation of encouraging in hospital care. It was further recommended that the Boards of both Blue Cross and Blue Shield be requested to give these recommendations immediate consideration in order to instigate a change at the earliest possible date.

3) The U.S. Justice Department suit against Pathologists.—That the Council on Specialty Medicine relate to the Board of Governors its unanimous concurrence in recognizing that the Justice Department suit against the Pathologists is of significant concern and involves all of organized medicine and further that it be recommended to the Board of Governors that every financial assistance possible be provided in any reasonable and proper manner which may be appropriate. It was further recommended that legal counsel advice and opinion be obtained regarding the legality and manner in which financial contributions may be made by individuals, county medical societies, specialty groups, etc., to be used in behalf of the Pathologists in their defense against the U. S. Department of Justice suit.

Summary Comments:

In addition to these recommendations the Council has been concerned chiefly with trying to arrive at an up-to-date Relative Value Study based on the recommendations of each Specialty Group. This has been forwarded to the Fee Schedule Committee in the hope that the Florida Medical Association can take some definite steps to work out satisfactory schedules wherever they are unavoidable. The most unsatisfactory of all at the present time is the method by which the Florida Industrial Commission arrives at charges which they will allow the Insurance Companies to pay.

Another significant item pending Council consideration is the Board of Governors communication regarding the status of the Florida Psychiatric Society since it was placed on probation. This matter has been referred to the Council with the request that it work out a plan for better coordination of Specialty Group Programs with the FMA. In referring this matter to the Council the Board further commented that even though a specialty group were a separate corporation, when it received recognition from the FMA, there were responsibilities which went with it, and the FMA could not allow unilateral action by recognized specialty groups which would tend to destroy the effectiveness of organized medicine in Florida. Council deliberation regarding this matter will be reported to the Board following its next meeting.

Dr. Fleming: "The Reference Committee considered the Board of Governors' Report, Action #21, Regional Program for Heart Disease, Cancer and Stroke, and recommends that it be approved as printed in the Handbook.

"Mr. Speaker, I move the adoption of this portion of the report."

(See Board of Governors' Report, page 680.)

Dr. Fleming: "The Reference Committee considered Resolution No. 67-13, Statement of Policy on Chiropractic, and recommends it be approved as printed in the Handbook.

"Mr. Speaker, I move the adoption of this portion of the report."

Motion seconded and carried.

Resolution 67-13

Statement of Policy on Chiropractic Board of Governors

It is the position of the medical profession that chiropractic is an unscientific cult whose practitioners lack the necessary training and background to diagnose and treat human disease. Chiropractic constitutes a hazard to rational health care in the United States because of the substandard and unscientific education of its practitioners and their rigid adherence to an irrational, unscientific approach to disease causation.

In 1965, a United States District Court, in upholding a state's constitutional right to refuse to license chiropractors, said that "since chiropractic claims to be a complete and independent healing art capable of curing almost all kinds of disease, the state Legislature may have felt that the requirement of a foundation in materia medica and surgery . . . would be a protection to the public." Without dissent, the United States Supreme Court affirmed the decision.

The wisdom of these decisions by the nation's highest courts justifies the medical profession's educational program of alerting the nation to the public health threat posed by the cult of chiropractic.

Patients should entrust their health care only to those who have a broad scientific knowledge of diseases and ailments of all kinds, and who are capable of diagnosing and treating them with all the resources of modern medicine. The delay of proper medical care caused by chiropractors and their opposition to the many scientific advances in modern medicine, such as life saving vaccines, often ends with tragic results.

Dr. Fleming: "The Reference Committee considered Resolution No. 67-16, Millis Report, and recommends adoption with the following amendment beginning with the fifth 'Whereas.' "

"Resolved, That a special committee of the Florida Medical Association be appointed to study this report and invite comments from all segments of the profession and report its findings and recommendations to the Board of Governors of the Florida Medical Association as soon as practicable and to the House of Delegates at the next regular meeting in May of 1968; and be it further

"Resolved, That the Florida Delegates to the American Medical Association be instructed to ask for a delay in final recommendations on the part of the American Medical Association House of Delegates until after that date.

"Mr. Speaker, I move that this resolution as amended be referred to the Board of Governors

for consideration and implementation."

Motion seconded and carried.

Resolution 67-16

Millis Report
Orange County Medical Society

(Not Approved—Referred to Board of Governors)

Whereas, The Millis Report represents a document of far-reaching import to the medical profession, and

Whereas, It was presented to the American Medical Association House of Delegates in June of 1966, and

Whereas, The House of Delegates referred it to the State and Local societies for consideration and comment; and

Whereas, This report has apparently been given little attention, and

Whereas, This document deserves extensive discussion and analysis, be it further

RESOLVED, That a special committee of the Florida Medical Association be appointed to study this report and invite comments from all segments of the profession and report its findings and recommendations to the Board of Governors of the Florida Medical Association as soon as practicable and to the House of Delegates at the next regular meeting in May of 1968; and be it further

RESOLVED, That the Florida Delegates to the American Medical Association be instructed to ask for a delay in final recommendations on the part of the American Medical Association House of Delegates until after that date.

Dr. Fleming: "The Reference Committee considered Resolution No. 67-18, Internships, and recommends that this resolution be referred to the Board of Governors, with the suggestion that it be considered by the Committee which will study the Millis Report.

"Mr. Speaker, I move this resolution be referred to the Board of Governors."

Motion seconded and carried.

Resolution 67-18

Internships
Escambia County Medical Society

(Not Approved—Referred to Board of Governors)

Whereas, The revisions of the "Essentials of an Approved Internship" (JAMA 196:513, May 9, 1966) claim to abolish the mixed internships and "redefine" the rotating internship but do in fact discard the rotating internship, and

Whereas, The redefinition of a rotating internship presented to and approved by the AMA House of Delegates in 1966 was incomplete and therefore misleading, and

Whereas, The eventually released details permitting some 700-odd options which prospective interns may now demand to make effective rotation, coherent scheduling, well-rounded preparation for practice and consistent manning of hospital services impossible, and

Whereas, The reason given for this change, i.e., "a rapidly increasing acceptance of the mixed internship with a commensurate decrease in rotating internships" is contrary to statistics published by the Council on Medical Education, be it further

RESOLVED, That the previous action of the AMA House of Delegates approving the revision of the "Essentials of an Approved Internship" be rescinded, and be it further

RESOLVED, That straight internships be continued, that mixed internships by the old definition be abolished and that in approved rotating internships, internal medicine and general surgery be paired so that each intern takes four months of one (either consecutively or in two units of two months each) and two of the other, that each intern take two months each in obstetrics and gynecology and in pediatrics, and that the remaining two months be spent optionally in psychiatry, pathology, radiology, anesthesiology, medical or surgical subspecialties or under preceptors in group or individual practice.

Dr. Fleming: "The Reference Committee considered Resolution No. 67-19, Medical Education, and after considerable discussion by a number of interested individuals who appeared at the committee's hearing, the following substitute resolution is submitted."

Dr. Fleming read the substitute resolution.

"Since ideas embodied in the substitute resolution are discussed fully in the Millis Report, the Committee recommends that the substitute resolution be referred to the Board of Governors with the suggestion that it be considered by the Committee which will study the Millis Report.

"Mr. Speaker, I move that this resolution be referred to the Board of Governors."

Motion seconded and carried.

Substitute Resolution 67-19

Medical Education

(Referred to Board of Governors)

Whereas, The present day needs of medical education at all levels demand local and national leadership: and

Whereas, The practicing physician and unaffiliated teaching hospitals have lost a voice in the establishment of educational policies; be it therefore

RESOLVED, That the American Medical Association Council on Medical Education be reconstituted as an overall policy-making body for medical education with due representation from the Association of American Medical Colleges, the Association of Hospital Directors of Medical Education, the nonaffiliated teaching programs, the American Academy of General Practice, the American College of Physicians, the American College of Surgeons and Representatives-at-large elected by the House of Delegates of the American Medical Association.

Dr. Fleming: "The Reference Committee considered Resolution 67-29, Postgraduate Education, submitted at the first meeting of the House and feels that the idea and ideal which this resolution represents is commendable and recommends that this resolution be considered by the special committee which is studying the Millis Report.

"Mr. Speaker, I move that this resolution be referred to the Board of Governors."

Motion seconded and carried.

Resolution 67-29

Postgraduate Education
Broward County Medical Association

(Not Approved—Referred to Board of Governors)

Whereas, the Florida Medical Association's Council on Medical Education and Hospitals has recommended that they take an active part in all phases of medical education, and make every effort to assist in the coordinating the activities of all institutions and agencies, particularly those involved in continuing education of physicians, and

Whereas, the current activity of the American Academy of General Practice has an existing program of great merit to maintain the quality of its membership through continuing education, it is

RESOLVED, That a study committee be appointed by the House of Delegates of the American Medical Association to determine the feasibility of other specialty groups adopting a requirement of annual or biennial hours to be spent in postgraduate education as a requirement to maintain certification by the respective specialty board, and be it further,

RESOLVED, That the delegates of the Florida Medical Association to the American Medical Association House of Delegates be instructed to introduce this resolution for the consideration of the National Body.

Dr. Fleming thanked the members of the Association who appeared before his committee and also the members of the committee for their dedicated service.

Dr. Fleming: "Mr. Speaker, I move the adoption of the Committee's report as a whole as amended.

Motion seconded and carried.

Dr. James T. Cook, Vice Speaker, assumed the Chair.

Report of Reference Committee No. 2

Public Policy

Dr. Abbott Y. Wilcox Jr., Chairman: "Mr. Speaker, Mr. President, and Members of the House of Delegates:

"Your Reference Committee on Public Policy has considered each of the items referred to it and submits the following report. The Committee's recommendation on each item will be submitted separately and we request that each item be acted upon separately before proceeding to the next.

"The Reference Committee considered the report of the Council on Allied Professions and Vocations and recommends amendment of the report of the Committee on Medical Technologists, the fourth paragraph, section 1, by deletion of all but the first sentence of that paragraph.

"Mr. Speaker, I move the adoption of this portion of the report be amended."

Motion seconded and carried.

Dr. Wilcox: "The Reference Committee considered the supplemental report of the Council on Allied Professions and Vocations and recommends the following amendment:

"Paragraph two (2) to read as follows: 'That the Florida Medical Association approve and endorse the development of a Medical Assistants Training Program in appropriate Junior Colleges after review and approval of the curriculum by the advisory committee to the State Department of Education.'

"Mr. Speaker, I move the adoption of this portion of the report as amended."

Motion seconded and carried.



Serving as Reference Committee II were Drs. Abbott Y. Wilcox, chm., James W. Walker, John C. Fletcher, Lee Rogers Jr. and Richard C. Clay.

Council on Allied Professions and Vocations

JESSE W. CASTLEBERRY, *Chairman*

Council:

The Council held one meeting during the past Association year, February 11, 1967, and considered various committee reports as follows:

Committee on Medical Assistants—The chairman believes the criteria for the Broward County Junior College Medical Assistants Training Program needs further consideration, but that it is perhaps the most comprehensive

program of its type being undertaken in the state. Plans are underway to have this curriculum reviewed by the Advisory Committee to the State Board of Education.

Committee on Medical Technologists—The Ad Hoc Committee on Medical Technologists met March 17, 1967 and made a detailed evaluation of the Florida Medical Technology Law (Chapter 483, Florida Statutes) and the 12 principles for revision of the law which earlier were formulated by the Committee and adopted by the 1966 House of Delegates. The following actions were taken as indicated:

1. Section 483.05 (Administration) amended to include principles II and IX as follows:
"The State Board of Health is hereby vested with full and complete authority to administer the provisions of this chapter.

2. In discussion of principle III, it was recommended that no reference should be made to any such specific regulation because of the rapid changes in regulations concerning laboratories promulgated by the U. S. Department of Health, Education, and Welfare.

3. Principles V and VI were incorporated as subsections under section 483.15, rewording the subsection as follows:
"(1) Proper supervision of laboratories under this law shall include renewal of licenses on an annual basis and a formal inspection every one to three years. The board may utilize the services of such inspectors, enforcement officers and clerical assistants as may be required. The qualifications of any inspector must meet or exceed those required for a laboratory director. An inspector must have qualifications at least equal to the laboratory director of any laboratory which he inspects.
"(2) A program for the continuing evaluation of laboratory proficiency shall be established. To carry out this program, the board may inspect all laboratories at any time . . ."

4. Additional subsections were added to section 483.15 as follows: (these incorporate the intent of principle IV)
"(5) Funds shall be provided by the state for the adequate administration of this law if the fees paid by the registrants or licensees are inadequate for administration.
"(6) Principle VII shall be added as a new subsection (6) as written.

5. No action taken on principle VIII as it is provided for in the current law, and any further implementation may be provided or accomplished through regulation. Principle X was also believed to be properly provided for in the current law.

6. An additional subsection was added under section 483.11 to incorporate the intent of principle XI as follows:
"(4) The board may grant temporary licenses to candidates it deems properly qualified for a period not to exceed six months. Such licenses may be renewed for an additional six months at the discretion of the board."

7. Section 483.02 (Definitions) was amended by adding a new subsection (4) and renumbering the present subsection (4) as follows:
"(4) 'Medical Laboratory' means any institution, building or place which provides through its ownership or operation an organization which employs methods and instruments of precision for the examination of tissues, secretions and excretions of the human body and its functions in order to diagnose disease, follow the course of disease or aid in the treatment of such disease, or which purports to offer such examinations. These examinations may include procedures employed to diagnose disease by the examination of tissues removed at surgery or ascertain the cause of death and the results of treatment by means of necropsies.
"(5) The 'board' is the State Board of Health."

8. Subsections (1) and (3) of section 483.03 (Exemptions) to be amended so as to include the intent of principle XII.

9. Amendment of principle I is recommended to provide that licensing of laboratory personnel wherever applicable be compatible with the revision of the law.

Committee on Nursing—A health occupation survey, implemented by the State Department of Education, is being conducted to determine to what extent a shortage of nurses exists in Florida.

A statewide nurses salary reporting program is underway and is expected to provide information on which to base nursing salary recommendations.

The Florida State Board of Nursing is proposing legislation to increase licensure and endorsement fees, proceeds of which are expected to provide a means of financing responsibilities charged to the Board by Florida law.

Committee on Pharmacy—Discussion was held regarding the Hart Bill and this matter was referred to the Board of Governors, where action was taken to oppose this bill.

Committee on Physical Therapy—A problem has developed in Leon County regarding occupational therapists and speech therapists not having received the payment to which they were entitled under Medicare. It was suggested that Blue Cross-Blue Shield is misinterpreting Medicare regulations. Plans are underway to discuss the matter with the proper individual at Blue Cross-Blue Shield.

Concern regarding the possible need for representation of occupational, speech and inhalation therapists and surgical technicians on the Council has been demonstrated. Until separate committees on these specific paramedical groups are established, it was decided to place the occupational therapists, speech therapists and inhalation therapists under the Committee on Physical Therapy, and the surgical technicians under the Committee on Nursing.

Committee on Religion—A workshop on medicine and religion was held in Orlando prior to the Ninth Annual County Medical Society Presidents and Secretaries Conference.

Committee on Veterinary Medicine—Mutual medical and veterinary profession research projects included comparative studies of suture materials, anatomy and physiology of the four Florida poisonous snakes, effects and treatment of envenomation, treatment of adhesive tenosynovitis in canines and traumatic neuromas. The committee recommends an appointed member from the FMA attend the annual meetings of the Florida State Veterinary Medical Association.

Supplemental Report

The Council on Allied Professions and Vocations, consistent with the recommendation adopted by the 1966 House of Delegates that the Florida Medical Association take the initiative in establishing the State's education standards of all paramedical personnel; that these standards be instituted among the vocational schools, junior and senior colleges and other institutions qualified, and that these standards should be the guide established as the "basis" for adequate training in all the paramedical fields, presents the following recommendation for adoption by the House of Delegates:

That the Florida Medical Association approve and endorse the development of a Medical Assistants Training Program in appropriate Junior Colleges after review and approval of the curriculum by the Advisory Committee to the State Department of Education.

Dr. Wilcox: "The Reference Committee considered the report of the Council on Medical Services and recommends it be amended as follows: Committee on Vision—the deletion of the

second paragraph, section 18, page 26 of the Handbook, and sections 20, 21 and 22, substituting the following recommendations for section 22: 'That the Florida State Department of Education be requested to use a referral form similar to the one in use by the Dade County Department of Public Health for the referral for school screening examinations for proper medical care and that all forms currently in use be eliminated.'

"Mr. Speaker, I move the adoption of this portion of the report as amended."

Dr. Thomas S. Edwards, Duval, Chairman of the Committee on Vision: "Subsequent to the meeting of the Reference Committee on Thursday, the Medical Advisory Committee to the Prevention of Blindness met on Friday. It is recommended that the last paragraph of section 19 be changed as follows: 'Therefore, be it resolved that when vision screening is being carried out, a group of figures shall be presented in preference to a single figure wherever possible within the limitations of the age of the child, cooperation of the child and training and experience of the examiners.'

"This is being recommended by the Committee on Vision and yesterday was unanimously approved by the Florida Society of Ophthalmology.

"Further, the Florida State Board of Health met yesterday and we would like to make the following recommendation for section 22 which was just read by the chairman: 'That the Florida State Department of Education be requested to use Florida State Board of Health referral form A-28, revised 4/1/67, adopted 5/13/67, for referral for school screening examinations for proper medical care and that all forms currently in use be eliminated.'

"Mr. Speaker, I move the adoption of these two amendments."

The Speaker ruled that these would be voted upon separately—the last one first.

Motion was seconded and carried.

Dr. Edwards restated his first amendment to section 19.

Motion was seconded and carried.

In response to a question from the floor, Dr. Edwards explained that his amendment for section 22 did not conflict with the recommendations of the Reference Committee, as the form A-28, which was adopted by the Florida State Board of Health, is the same form as that in use by the Dade County Department of Public Health as recommended by the Reference Committee.

Motion was carried to approve the recommendations of the Reference Committee as amended.

Council on Medical Services

WILLIAM R. DANIEL, *Chairman*

Council:

During The Association's 1966-67 year, the Council held meetings September 10, 1966, and March 5, 1967. Both meetings were held in Orlando. The first meeting was for the purpose of evaluating and planning the individual committees' programs; the second was to consider recommendations to be included in the Council's annual report.

Because most of the Council's 13 committees conduct extensive individual programs, summaries of each committee's activities would be voluminous. The major role of the Council is to serve as a coordinating body for avoidance of duplication of effort. Another important function is to screen, modify where necessary, and adopt proposals originating in its committees.

Although practically all the committees were active during the past year, especially notable were the Committee on Child Health in its continuing excellent work as School Health Medical Advisory Committee to the State Department of Education and State Board of Health, the Committee on Emergency Medical Service in handling an increased load of physician essentiality determinations as state medical advisory committee to the Selective Service System, the Committee on Maternal Health in its efforts to obtain passage of a needed revision of the state's obsolete abortion laws, the Committee on Mental Retardation in its attempts to secure important cooperation among the various groups in that area, the Committee on Public Health in its extensive study and recommendations on a wide variety of often controversial issues, and the Committee on Vision in accelerating a number of activities to assume the Association's leadership in that field.

All of the following consecutively numbered recommendations and resolutions have been carefully reviewed and adopted by the Council as a body. To facilitate the procurement of necessary additional background information, the name of the originating committee precedes each series of recommendations.

Recommendations:

(Committee on Blood)

1. Whereas, The Federal Trade Commission ruled against Kansas City hospitals, community blood banks and hospital pathologists as combining illegally to restrain commerce in human whole blood, and

Whereas, This ruling places blood and human tissues in the status of an item of trade which can imply and command a guarantee of quality that is impossible to assure, and

Whereas, This ruling establishes restraint of freedom of physicians and hospitals to use and require use of tissue (including blood) which their medical judgment deems best, and

Whereas, This ruling creates restraints, liabilities and demoralizing forces on voluntary and nonprofit blood banking programs, and would create forces for the disruption of current growth and development of quality blood banking, blood distribution and increased litigation related to the processing and distribution of any human tissue for therapeutic use, and

Whereas, Federal legislation is being and has been introduced to place human tissues, including blood, as processed by non-profit medical organizations, beyond any restraint of trade laws of the United States;

THEREFORE BE IT RESOLVED, That the Committee on Blood be authorized to proceed with any and all efforts available to support and implement passage of such legislation and that the Council on Legislation and Public Agencies and delegates to the American Medical Association be instructed to make vigorous efforts to complete such legislation this year.

(Committee on Child Health)

2. That the Association support passage of a law in Florida limiting the distribution of LSD and other hallucinatory agents.

3. That the administration of oxygen in school clinics and athletic events be restricted to medically trained persons.

4. Whereas, The youth of Florida have numerous unresolved health-related problems, and

Whereas, Education directed toward the acquisition of scientifically accurate health knowledge and the development of positive health attitudes and practices is necessary to help youth find solutions to their own health problems, and

Whereas, The junior and senior high schools in Florida are not providing consistently a significant degree of health education for our youth, and

Whereas, Direct instruction in separate health classes is known to be of greater value than the "hit-or-miss" pattern of instruction in which health topics are included in other subject-matter areas;

THEREFORE BE IT RESOLVED, That the Florida Medical Association recommend to the Florida State Department of Education that a well-planned, sequential program of health education based on the health needs of Florida youth be included in the junior and senior high school curricula, and that this program be implemented through the use of well-prepared health education teachers. It is further recommended that a minimum of one semester's instruction in health be required at each level, and that additional elective opportunities be provided for those students who are interested in learning more than the required courses offer.

(Committee on Emergency Medical Service)

5. Reaffirmation of previous recommendations that disaster and Selective Service committees of county medical societies be continuing committees and that changeovers in membership not be made each year.

(Committee on Hearing)

6. That the State Board of Health be encouraged to expand their child hearing testing and treatment programs in the state.

(Committee on Maternal Health)

7. That an anesthesiologist, an internist, and a representative from the Department of Obstetrics and Gynecology of the University of Miami School of Medicine be added to the Committee on Maternal Health in an ex-officio consultant capacity.

(Committee on Mental Retardation)

8. That Chapter 383.14, Florida Statutes, be retained as written and that no changes be made which would make PKU testing mandatory during the 1967 session of the Florida legislature.

9. That the State Board of Health be requested to assist in developing a needed manual of management of PKU patients.

10. That scientific articles on mental retardation be encouraged by professional publications in the state, primarily the Journal of the Florida Medical Association.

11. That efforts be made to achieve improved communication between the various organizations, groups and agencies concerned with the field of mental retardation.

12. That increased and improved research into the cause and prevention of mental retardation be carried out.

(Committee on Rural Health)

13. That each county medical society be requested to have a Committee on Rural Health and that, if feasible, in rural and smaller counties this committee also serve as a medical advisory committee to the county school board augmented by representation from the dental society.

14. That immunization programs be promoted, with special emphasis on measles vaccine.

15. That emphasis be placed on the elimination of shallow wells as water sources for farm homes.

16. That rural families be educated and informed of the need and availability of health insurance.

17. That emphasis be placed upon farm accident prevention and the encouragement of at least one member of each household being trained in first aid.

(Committee on Vision)

18. Whereas, There has been a steady encroachment on the field of medicine by the optometrists, and

Whereas, This patient referral to non-medical practitioners can, and indeed has, bordered on malpractice, in that the proper medical care for the patients may be very well denied or delayed, since diabetes, hypertension, hyperopia, brain tumors and other medical problems may be undiagnosed;

THEREFORE BE IT RESOLVED, That the Florida Medical Association conduct a survey to determine the percentage of physicians who are referring patients to optometrists; that the Association institute an educational campaign of all its members as to the differences, qualifications, and training of ophthalmologists and optometrists, and that the Council on Medical Services and/or the Board of Governors have a careful study made of the entire problem.

19. Whereas, It has been shown that many cases of amblyopia exhibit a separation difficulty before a marked drop in visual acuity is manifested, and

Whereas, This will lead to cases of amblyopia being missed when vision is screened with a single letter exposed;

THEREFORE BE IT RESOLVED, That when vision screening is being carried out, a group of figures shall be presented in preference to a single figure wherever possible within the limitations of the age of the child, cooperation of the child, and training and experience of the examiners.

20. (22) That the State Department of Education be requested to use Florida State Board of Health referral form A-28, revised 4/1/67, adopted 5/13/67, for referral for school screening examinations for proper medical care and that all forms currently in use be eliminated.

Dr. Wilcox: "The Reference Committee approved the report of the Council on Voluntary Health Agencies as printed in the Handbook.

"Mr. Speaker, I move the adoption of this portion of the report."

Motion seconded and carried.

Council on Voluntary Health Agencies

MASON ROMAINE III, *Chairman*

Council:

During the Association's 1966-67 year, the Council on Voluntary Health Agencies held meetings May 28, 1966, and February 11, 1967. The latter meeting included the Council's annual joint conference with the executive directors of the Florida voluntary health agencies officially recognized by the Association.

Although there were no changes in direction or emphasis, the past year saw a continuing refinement of the program as the Council concerned itself with a variety of activities. There are no new specific recommendations to be made at this time. The following brief summary of the Council's activities is presented by general subject.

Recognition Program—As in past years, the programs of the eleven officially recognized voluntary health agencies were carefully reviewed. No grounds were found for withdrawal of recognition of any individual agency, although a temporary withholding of recognition was considered for several who were tardy in supplying requested information. A pending application for one additional agency is under study. The following organizations currently are recognized:

Florida Chapter, Arthritis Foundation
Florida Society for the Prevention of Blindness
Florida Division, American Cancer Society
United Cerebral Palsy of Florida
Florida Society for Crippled Children and Adults
Florida Heart Association
Florida Association for Mental Health
National Multiple Sclerosis Society
The National Foundation
Florida Association for Retarded Children
Florida Tuberculosis and Respiratory Disease Association

Liaison with Voluntary Health Agencies—Late in 1966, the Florida Voluntary Health Agencies Coordinating Committee, which had existed for several years as an informal liaison mechanism for the state's voluntary health agency executives, dissolved itself and a majority of its former members established an expanded, more formal organization known as Florida Voluntary Health Association, Inc. After studying its objectives, the Council endorsed the formation of this new group and plans to maintain close relations with it. The Council participated in the 1966 Annual Institute for Voluntary Health Agencies held in Miami Beach under the former Coordinating Committee's sponsorship, and will cooperate with the new association in the 1967 Institute, to be held in August.

Charitable Solicitations Law—The Council has worked closely with the Office of the Secretary of State in the implementation of Florida's new law regulating charitable solicitations, which was passed in 1965. Two members of the Council have participated as members of the Secretary of State's advisory committee in formulating necessary amendments for improved operation of the law, which is considered a beneficial step forward in the interest of Florida's citizens and legitimate health and other charitable organizations.

AMA Council on Voluntary Health Agencies—Close liaison has been maintained with the American Medical Association Council on Voluntary Health Agencies, of which the chairman is a member. Recently the national group has devoted considerable effort to the coordination of professional educational activities of voluntary health agencies, a subject of concern which likely will receive increased attention in Florida.

County Medical Society Activities—Because the Council is fully aware that no program can be successful until applied locally, several county medical society "pilot" voluntary health agency programs are being carefully studied. Informational materials and assistance will be furnished to all county medical societies to provide guidelines for establishing liaison and leadership with voluntary health agency chapters in their areas.

Inquiries from Profession and Public—The Council has received inquiries from members of the medical profession and the public relative to the legitimacy of various local, state and national organizations in the voluntary health field. In each case, information is supplied as completely as possible or referral is made to the proper sources.

Dr. Wilcox: "The Reference Committee considered the Board Actions No. 29, Cardiovascular Screening Program; No. 30, Teenage Alert, and No. 31, Maternal Health, on page 26 of the Handbook and proposes an amendment to No. 29 by adding the following: 'providing that implementation be dependent upon the approval of the county medical society.'

"Actions 30 and 31 were approved as printed.

"Mr. Speaker, I move the adoption of this portion of the report as amended."

(See Board of Governors Report, page 681)

Dr. Wilcox: "The Reference Committee considered Resolutions 67-3 and 67-8 together as the contents of both were the same, and wishes to submit the following substitute Resolution with amendments."

Dr. Wilcox read the substitute resolution.

"Mr. Speaker, I move the adoption of this portion of the report as amended."

Motion was seconded.

Dr. Maurice M. Greenfield, Dade: "While not in total disagreement with the spirit and philosophical thinking of this substitute resolution, I feel this is not in the public interest and certainly will not improve our image and posture with the public and I move that this resolution be tabled."

Motion was seconded, and the Speaker ruled that the motion to table precluded any discussion at this time.

The motion to table failed, and the Speaker asked for discussion on the main motion.

Dr. Joseph A. Shelley, St. Johns: "I believe one of the things that worries and concerns some of the doctors is the possibility that the Florida

Medical Association may be sued in court by Mr. Wilbur J. Cohen if this resolution is passed. I would like to point out that Dr. Marjorie Shearon has documented and indicted the whole background of this man and nothing we can say here is strong enough to point out what he is. You don't have to worry about a thing—Mr. Cohen would not sue us—he has never sued Dr. Shearon, because he is afraid to have his record discussed in a court of law in this country; he would probably be deported. I would like to see this resolution passed."

Dr. Jesse W. Castleberry, Orange: "Mr. Speaker, Gentlemen: It is our duty as an organization of doctors and as citizens in a free society to speak out on matters of deep concern to the people when such matters come to our knowledge.

"Doctors in this country opposed with much energy this appointment and five years later, and one year after Medicare, we can say, 'we told you so,' and we still want him removed. The tragedy of the compulsory way of life in health care will be ours and our patients if we permit this to go on. Let us be forceful in presentation and determined in purpose, resourceful in remedy. The Congress will do it and the President will do it if we speak out. There has been full consideration by legal counsel and there is no libel. We have the right to speak out about public officials and their functioning in office. Complete documentation of the premises in this resolution was presented to the Reference Committee and is available here and available now for the asking, point by point. There is voluminous documentary evidence in support of this resolution and not the least doubt that a full evaluation of Health, Education, and Welfare functioning is in order by the Congress.

"This House of Delegates now has the opportunity to express this concern as an assembled body, representative of the doctors of medicine."

Dr. DeWitt C. Daughtry, Dade: "I think we all feel rather strongly about this, but I am going to have to speak against this because anything we do along this line as a body will be construed by the public as having an ulterior motive. I think we can do more as individuals with our Congressmen, but I believe it is out of order for us to approach it in this manner."

Dr. Edward J. Lauth Jr., Dade: "I agree with Dr. Daughtry. As was said this morning in discussing this, this is an exercise in pragmatic futility. We can gain nothing by such action. There is considerable opinion outside of the medical profession opposing this man and we all may oppose him in principle, but I think we are sticking our necks out. Certainly President Johnson is not going to listen to the Florida Medical Association or the American Medical Association. He did not listen to the members of Congress who opposed the appointment of this man, and I believe we will only damage our cause, because it cannot be accomplished by this action; that is, the removal of Wilbur Cohen. And, we will have delegates and representatives in Washington who will have to do business with this man, and he can use this as an ax against us. I again repeat, this is an exercise in futility."

Dr. Jere W. Annis, Polk: "I would speak to you briefly on behalf of the Florida delegates to the AMA. Our delegation has asked unanimously that this resolution be defeated. All of us are in agreement with the principles involved and will do everything possible to bring about what you are asking. This gives us no new weapon, no effective weapon, and puts us in a position where we will not be as effective, dealing in personalities, which we think, perhaps, are beneath the dignity of this organization. I would ask you to vote against this resolution because it will not help us, and we would like to go up there without this charge to attack Mr. Cohen."

Dr. Carl N. Reilly, Charlotte: "I respectfully suggest that our colleagues who are opposing this resolution may not have thought this matter all the way through.

"It is true it would be difficult to persuade the President to remove a cabinet officer; however, we often attribute to our President and to the members of Congress knowledge which they do not possess. We have found in talking to several—not one, but several—Congressmen that they do not know the background of this individual. Further, if we have never asked the President, if we have never exercised our duty as citizens, then can we wonder if he never considers it? I maintain that we have a duty to our children to see that this matter is brought not just to the President of the United States, not just to the Congress, but to the people of the United States, because the future freedom in this country depends upon the public learning about matters such as we are discussing today."

Dr. Lees M. Schadel Jr., Broward: "Because of the indecisive vote, I move this be referred to

the Board of Governors for further deliberation."

Motion was seconded.

Dr. Castleberry, Orange: "To refer this to a committee or any other body, or to do anything with it except dispatch it by the full House of Delegates may be to defeat it. If it is to be defeated, I ask that it be defeated here. If it is to be passed, I ask that it be passed here. It would be far more effective in either case if the full House of Delegates performs the function."

Dr. Sackett, Dade: "In my position in Tallahassee, these resolutions are being constantly proposed before the Legislature and the same arguments are brought against them—that they are an exercise in futility, and yet those that have been brought up, to my knowledge, have all been passed by the Florida Legislature. If we don't start pouring things in from all sides we will never accomplish anything."

Dr. David Kirsh, Dade, asked that Dr. Edward Annis speak on this subject.

Dr. Edward R. Annis, Dade: "I have publicly, repeatedly and at every opportunity, which dates back long before Wilbur Cohen was nominated as an assistant secretary, stated that this man is the archenemy of American medicine. Today, he is a veritable Czar on matters pertaining to legislation. I was one of those who opposed his nomination. Senator Smathers told me and others, personally, that we might as well let him be appointed because we would have him where we could keep an eye on him. I told the Board of Trustees of the American Medical Association one year ago that I thought it would be very wise, as one of the price-tags for our continued support, to ask for the removal of the Undersecretary who is an enemy of medicine. This morning at the Dade delegation meeting, however, the resolution as rewritten by the Reference Committee was referred to as one that doesn't say very much. The first 'Whereas' refers to 'by his actions,' the second, 'by his philosophy,' and it doesn't spell out any kind of an indictment upon which we could reach a conclusion justifying such action. I did agree that I felt this is the case.

"My opinion is that the President is not going to pay attention to the Florida Medical Association, but I think Walter Sackett hit it pretty well. I said this morning that I am neither strongly for nor against this resolution; there is no question how I stand about this man.

"Now how you want to word it is a different thing. I would agree with those who say that this is not as strong as it might be. I would think, however, if the resolution doesn't do anything but draw the attention of the American people to what I consider his nefarious activities, it would not necessarily be an exercise in futility."

The Speaker called for a vote on the motion to refer and the motion to refer was defeated.

The Speaker then called for a vote on the main motion to approve the substitute resolution. A division of the House was called for and the motion carried.

Substitute Resolution 67-3 and 67-8

Wilbur J. Cohen

Undersecretary of Health, Education, and Welfare

Whereas, the ideology of Wilbur J. Cohen prevents an impartial administration of his duties as Undersecretary of Health, Education, and Welfare, and

Whereas, the circumstances surrounding the confirmation of the appointment of Wilbur J. Cohen as Undersecretary of Health, Education, and Welfare are open to question, and

Whereas, Mr. Cohen has demonstrated by his actions and words over and over again during the past 30 years and at present that he is determined to nationalize medicine in the United States, and

Whereas, Mr. Cohen's administration of Public Law 89-97 has, in our opinion, contravened the legislative intent of the act, therefore be it,

RESOLVED, That this House of Delegates does request of the President of the United States that he be replaced as Undersecretary of Health, Education, and Welfare, does seek full evaluation by Congress of his background, and of his department's operations.

RESOLVED, That this Resolution be given to a Florida Delegate to the American Medical Association House of Delegates to be proposed for adoption at their next meeting, and Delegates from the Florida Medical Association be instructed to actively support this Resolution, and further

RESOLVED, That the Florida Medical Association officers shall aggressively and independently seek implementation of this Resolution regardless of its future disposition.

Dr. Wilcox: "The Reference Committee considered Resolution 67-24, Birth Certificates, and recommends the following amendment:

"In the last paragraph, an additional phrase be added to read as follows: 'provided that adequate safeguards are instituted to protect against the improper release of privileged medical information.'

"Mr. Speaker, I move the adoption of this portion of the report as amended."

Motion was seconded and carried.

Resolution 67-24

Birth Certificates
Walter W. Sackett Jr., M.D.

Whereas, the State of Florida is one of the five states without any appropriate provisions for recording birth defects on birth certificates, and

Whereas, this makes for an unfortunate situation in that there is no opportunity for compiling statistics as these defects are recognized at birth, and

Whereas, the Florida State Board of Health has indicated that a resolution from the Florida Medical Association would stimulate and speed up such a change in the birth certificate in the State of Florida so that it might be effective as of 1968, and

Whereas, for purpose of future use such information should be on a detachable portion of the certificate; therefore, now be it

RESOLVED, That the House of Delegates of the Florida Medical Association advise the State Board of Health of the tremendous importance of such information being included on the original birth certificate and; further be it

RESOLVED, That the same House of Delegates urge the State Board of Health to accomplish this forthwith and efficiently by revising the standard birth certificate to include a detachable portion to list birth defects, provided that adequate safeguards are instituted to protect against the improper release of privileged medical information.

Dr. Wilcox: "The Reference Committee approved the intent of Resolution 67-42, but recognizes that the bill may be amended so as to make it unacceptable.

"Mr. Speaker, I move the adoption of this portion of the report."

Motion seconded and carried.

Resolution 67-42

Medical Technology
Scheffel H. Wright, M.D.

Whereas, no legislation for the urgently needed revision of the present Medical Technology Act has been introduced by the Florida Medical Association in this session of the legislature, and

Whereas, the proposed new Florida Clinical Laboratory Act (Senate Bill 752 - House Bill 1122) is a good Act that meets most of the "Principles" approved by the 1966 House of Delegates,

Whereas, bills sponsored by the government reorganization committee have recommended placing full examining and regulatory powers in the State Board of Health; therefore, be it

RESOLVED, That the Florida Medical Association approve and lend their support toward the passage of Senate Bill 752 - House Bill 1122.

Dr. Wilcox: "The Reference Committee took no action on Resolution 67-43, due to the withdrawal of the resolution by the sponsor."

The Chairman expressed appreciation to the members of the committee and its secretary for their long and diligent work.

Dr. Wilcox: "Mr. Speaker, I move the adoption of this entire report as amended."

Motion seconded and carried.

Dr. Evans resumed the Chair.

Report of Reference Committee No. 3

Finance and Administration

Dr. Robert E. Zellner, Chairman: "Mr. Speaker, Mr. President, and Members of the House of Delegates:

"Your Reference Committee on Finance and Administration has considered each of the items referred to it and submits the following report. The Committee's recommendation on each item will be submitted separately, and we request that each item be acted upon separately before proceeding to the next.

"Your Reference Committee heard with approval the address of our President. It shares with him his pride in the many contributions of the distinguished Palmer family to this Association. Your Committee is of the opinion that the contribution of our President, Dr. George S. Palmer, to this Association is in keeping with the heritage of his family.



Composing Reference Committee III were Drs. Robert E. Zellner, chm., Nelson H. Kraeft, H. Quillian Jones Sr., Michael R. Blais and William M. Straight.

"Mr. Speaker, I move the adoption of this portion of the report."

Motion was seconded and carried. (Complete text of President's address begins on page 643).

Dr. Zellner: "The Reference Committee commends the Speaker on his clear, succinct and concise remarks intended to expedite the business of the House.

"Mr. Speaker, I move the adoption of this portion of the report."

Motion was seconded and carried.

Dr. Zellner: "The Reference Committee considered the report of the Board of Governors, Dr. George S. Palmer, Chairman, and concurs in the opinion expressed by the Chairman of the Board that the affairs of the Association have been handled in a superb fashion this year. The Committee feels that the entire membership of the Association owes its officers, councils and committees a debt of gratitude.

"Mr. Speaker, I move the adoption of this portion of the report."

Motion seconded and carried.

Dr. Zellner: "The Reference Committee enthusiastically concurs in the selection of Warren W. Quillian, M.D., as the recipient of the Association's Certificate of Merit. This is a fitting, if small, recognition of a life dedicated to his profession and his community. Dr. Quillian has been an inspiration to all of us who have had the good fortune to be associated with him.

"Mr. Speaker, I move the adoption of this portion of the report."

Motion was seconded and the Speaker cast a unanimous ballot.

Dr. Quillian came to the platform and the Certificate of Merit was presented to him by Dr. Palmer, who said, "Warren, it is one of my greatest pleasures today to be able to present the Association's highest award, the Certificate of Merit, to a fine gentleman and a real friend."

The House gave Dr. Quillian a standing ovation.



Dr. Warren W. Quillian of Coral Gables is congratulated by Dr. George S. Palmer, President, following presentation of the Certificate of Merit, the Association's highest award.

Certificate of Merit

WHEREAS, Warren Wilson Quillian, M.D., of Coral Gables, a life member of the Florida Medical Association, has rendered distinguished service to the public, to the medical profession and to the Association for over 40 years and is deemed worthy of the Association's highest award; and

WHEREAS, This conscientious physician was born in Atlanta, Georgia, on June 22, 1901; attended Boy's High School in Atlanta; received his premedical educatin at Emory University, Atlanta, and was granted the degree of Doctor of Medicine in 1924 by Emory University School of Medicine; served an internship at Grady Memorial Hospital, Atlanta, and the U.S. Marine Hospital, Savannah; and

WHEREAS, This favored physician, in 1926, entered the private practice of medicine in Coral Gables, where for over four decades he has continued to practice pediatrics; and

WHEREAS, This gallant doctor served his country during World War II in the Overseas Pacific Theatre Operation, Mobile Hospital III, Guam, attaining the rank of Commander, U.S. Navy Medical Corps, receiving a Navy Commendation; and

WHEREAS, This superlative physician has an enviable record of service to his community and to his profession; has been a clinical professor of pediatrics with the University of Miami School of Medicine since 1955 and a member of the University of Miami Board of Trustees since 1960; is an attending physician at Jackson Memorial Hospital, Miami, and Doctor's Hospital, Coral Gables; consultant in pediatrics to Variety Children's Hospital and to the National Children's Cardiac Home, both of Miami; was elected president of the Dade County Medical Association in 1947 and served on its Board of Trustees from 1948 to 1949; and

WHEREAS, This peerless physician has served in many and varied capacities in the Florida Medical Association; was President of the Association in 1963; was an associate editor of the Journal of the Florida Medical Association in 1936; served on the Child Health Committee from 1939 to 1942 and from 1948 to 1958, being appointed chairman of that committee for three successive terms from 1939 to 1941 and being an At Large member of that committee from 1959 to 1961; was a member of the Committee on Publications in 1942; served on the Reference Committee on Health and Education in 1948 and on the Reference Committee on Finance and Administration in 1953; served as chairman, Councilor Districts and Councils in 1958 and 1959; became a member of the Board of Governors in 1960 and was an Ex-Officio member of that governing body in 1961; and

WHEREAS, This pragmatic medical leader was a founding member of the Florida Pediatric Society and its president in 1947; was chairman of the Pediatric Section of the Southern Medical Association in 1941; holds membership in the American Medical Association, Southern Medical Association, Academy of International Medicine and is a Diplomate of the American Board of Pediatrics, a Fellow of the American College of Psysicians and a Fellow of the American Academy of Pediatrics and its president in 1951; therefore be it

RESOLVED, That the Certificate of Merit, the Association's highest honor, be presented to this fine gentleman, eminent member of the Association, scholar, teacher, community and professional leader, in recognition of his unselfish and generous expenditure of time and effort throughout the years on behalf of the public, the profession and the Association.

Dr. Quillian: "Dr. Palmer, I have the advantage over previous recipients to whom this was a complete surprise—I do read the Handbook. This a wonderful honor and I am very grateful to you. It has been given by those with whom I have worked and which makes it especially appreciated. The years we have worked together have brought with them the privileges of association and friendship with a large number of the finest people of the state—the members of the Florida Medical Association and their friends. This experience I shall always cherish.

"As Bob Hope might say, 'Thanks for the memory.'

"However, let's always look towards the tomorrows. I am hoping that in the years to come I shall have the privilege of continuing to work with you in this great organization, the Florida Medical Association.

"Let me quote from one of the works composed by that famous poet, Anonymous, who expressed his philosophy as follows:

"Sometime, when you're feeling important,
Sometime, when your ego's in bloom,
Sometime, when you take it for granted
You're the best qualified in the room.
Sometime when you feel that your going
would leave an unfillable hole,
Just follow this simple instruction,
And see how it humbles your soul.
'Take a bucket and fill it with water,
Put your hand in it, up to the wrist;
Pull it out; and the hole that's remaining
Is a measure of how you'll be missed.
You may splash all you please when you enter,
You can stir up the water galore,
But stop, and you'll find in a minute,
That it looks quite the same as before.'
The moral in this quaint example
Is do just the best you can.
Be proud of yourself, but remember,
There's no indispensable man."

Dr. Zellner: "Your Reference Committee wholeheartedly approves of the selection of Dr. James N. Patterson as the recipient of the Association's Certificate of Appreciation. That the quiet and self-effacing manner in which Dr. Patterson has for many years served this Association and the medical profession has not escaped the attention of the Board is commendable. Your Reference Committee feels that this award is long overdue.

"Mr. Speaker, I move the adoption of this portion of the report."

Motion was seconded and the Speaker cast a unanimous ballot for Dr. Patterson, who was escorted to the podium by Dr. Coleman.

Dr. Palmer presented the certificate and said, "It is a great privilege to present the Certificate of Appreciation to James N. Patterson, M.D. for outstanding services to the profession, to the Florida Medical Association and to the public, as set forth in the Principles of Medical Ethics. I am proud to have my name on the same certificate with Pat's."



Dr. James N. Patterson of Tampa accepts the Certificate of Appreciation from Dr. George S. Palmer, President.

Certificate of Appreciation

WHEREAS, James Nelson Patterson, M.D., of Tampa, a respected member of the Florida Medical Association, has rendered invaluable service to the Association, to the Medical profession, to the public and to his country, and merits special recognition for his achievements; and

WHEREAS, This distinguished physician was born in Onnalida, Pennsylvania on February 15, 1902; attended high school in Beaverdale, Pennsylvania; received a Bachelor of Science degree from Bucknell University, Lewisburg, Pennsylvania and the degree of Doctor of Medicine from the University of Cincinnati in 1929; completed an internship at Conemaugh Valley Memorial Hospital in Johnstown, Pennsylvania in 1929 and a residency at the Cincinnati General Hospital in 1932; and

WHEREAS, This youthful physician launched his career as a teacher in the Department of Pathology at the University of Cincinnati and during this time served for four years as pathologist to the coroner of Hamilton County, Ohio, two years as Professor and Head of the Department of Pathology at the Eclectic Medical College and as Director of Laboratories for the Hamilton County Tuberculosis Hospital; and

WHEREAS, This excellent physician moved to Florida, where on March 1, 1938 he became Director of the Bureau of Laboratories of the Florida State Board of Health, and as such developed an active program to improve the quality of the work in the branch laboratories of the State Board of Health and was instrumental in influencing the State Board of Health to employ two men with Ph.D. degrees and several with M.S. degrees so as to improve the caliber of work; and

WHEREAS, This dedicated doctor directed the Statewide Collection Program of Blood Plasma for the Armed Forces during the early days of World War II and served as Assistant State Health Officer in 1941 and 1942; and

WHEREAS, This loyal physician served his country during World War II, attaining the rank of Lieutenant Colonel in the U.S. Air Force; upon his return to civilian life moved to Tampa where he entered the private practice of pathology in 1946; becoming interested in hematology, he offered the only comprehensive services on the west coast of Florida for many years in the measurement of defects of blood coagulation; and

WHEREAS, This noted physician's increasing national reputation in pathology was recognized by his appointment to the Certifying Board of Pathology of the American Board of Pathology in 1952, on which he has served with distinction for 14 years, becoming Vice President of the Board in 1965 and President of the Board in 1966; and

WHEREAS, This outstanding physician has also been active in the affairs of organized medicine, being a past president of the Florida Society of Pathologists and having served as President and Secretary of the Florida Society of Blood Banks; as Secretary and as President of the Hillsborough County Medical Association as well as serving for many years on its Executive Committee and as a Delegate to the FMA; having served on the Editorial Board of the FMA for a number of years, was chairman of the Scientific Work Committee for two years, a member of the FMA Board of Governors, a member of the Board of Directors of the American Association of Blood Banks and chairman of the Committee on Clinical Chemistry of the American Society of Clinical Pathology, having served on the Nominating Committee of both these organizations and as well for the College of American Pathology; and

WHEREAS, This devoted physician has had a prominent role in community affairs, including serving as assistant medical director and medical director of the Southwest Florida Blood Bank; on the Board of Directors of the American Cancer Society, Florida Division, and as chairman of its Leukemia Committee; holding active membership in the Hillsborough County Heart Association, Hillsborough County Tuberculosis Association, Tampa Rotary Club, Tampa Philharmonic Society, Florida College Living Endowment, American Medical Association Educational Research Fund, University of Tampa Foundation, Bucknell University Alumni Club, University of Cincinnati President's Club and St. Andrews Episcopal Church; therefore, be it

RESOLVED, That the Certificate of Appreciation, established in 1961 for the purpose of acknowledging exceptionally meritorious service and awarded now for the second time, be presented to this remarkable member of the Association in recognition of his many contributions to the welfare of the Association, the state and the public.

Dr. Patterson: "It is with humility that I accept this certificate, knowing that in this room are many individuals who are as capable, and in many cases have done more for the medical association, than have I. I shall be ever grateful to the Hillsborough County Medical Association for nominating me for this award and to the Florida Medical Association for presenting it to me. Thank you."

The House rose in respect to Dr. Patterson.

Dr. Zellner: "Mr. Speaker, I might say it is one of the pleasures of serving on this Reference Committee to be able to share in making these awards."

"On Board Action No. 1, AMA Board of Trustees, it is with great sadness that your Reference Committee received the information of the death of a beloved member, Dr. Homer Pearson. Dr. Pearson's death creates a vacancy on the Board of Trustees of the American Medical Association, to which position he was re-elected in June 1966. Your Committee heard testimony from the President and Secretary of the Association re-emphasizing the previous action of the Board of Governors in supporting the nomination of another distinguished Florida physician, Edward R. Annis, M.D., to this vacancy. Your Committee heartily endorses this recommendation from the Board of Governors and further recommends that the Florida delegates to the American Medical Association be instructed to seek the nomination and election of Dr. Annis to this important position.

"Mr. Speaker, I move the adoption of this portion of the report."

Motion was seconded and carried.

Dr. Zellner: "On Board Action No. 3, Advisory Committee on Independent Laboratories, in view of the action taken by the House on recommendation of Reference Committee No. 2 concerning resolution No. 67-42, Medical Technology, the Committee recommends that no further action be taken on this item.

"Mr. Speaker, I move the adoption of this portion of the report."

Motion seconded and carried.

Dr. Zellner: "Action No. 5, Directory. Your Reference Committee heard considerable criticism of the present Florida Medical Association Directory because it fails to include an alphabetical roster by state rather than by county society. It is recommended that such an alphabetical roster be included in the 1968 Directory.

"Mr. Speaker, I move the adoption of this portion of the report."

Motion seconded and carried.

Dr. Zellner: "Action No. 6, Future Meeting Dates. The matter of future meeting dates and places is subject to so many variables that the Committee did not feel it was in a position to

make recommendations for dates as much as seven years in advance. It is recommended that this matter be left to the discretion of the Board of Governors, subject to satisfactory facilities and arrangements with the hotels involved.

"Mr. Speaker, I move the adoption of this substitute recommendation."

Motion seconded and carried.

Dr. Zellner: "Action No. 9, Florida Psychiatric Society. Evidence was heard indicating that the suspension of the Florida Psychiatric Society as a recognized Florida specialty group has been lifted by the Board of Governors and that this Society is now on probation. Further testimony was heard indicating that this suspension was brought about by faulty communication within the Florida Psychiatric Society and between the society and the office of the Florida Medical Association. In the opinion of your Reference Committee, the specialty societies are a valuable adjunct to the Florida Medical Association, and the Florida Medical Association, in turn, provides valuable services and support which these societies could get nowhere else. It is deplorable that misunderstandings from lack of communication should cause actions of this sort. It is hoped that all of the specialty societies will maintain open lines of communication and the best possible rapport with the Association and with each other so that the members of this Association will always be able to act together with the least possible friction for the common good.

"Mr. Speaker, I move the adoption of this portion of the report."

Motion seconded and carried.

Dr. Zellner: "Action No. 12, Medicare Claims Review. The Reference Committee considered this item and heard testimony concerning the definition of a community. The feeling was expressed that the community should be the state as a whole and equally forcefully expressed were opinions that the community should be on an area basis.

"Inasmuch as Blue Shield is now engaged in a law suit in which this conflict should be resolved, your committee recommends that no determination of this matter be made at the present time. [Therefore, it recommends that Item 12 be changed by inserting a period after the word 'review' in the eleventh line, and deleting the remainder of the sentence.] [Bracketed portion was tabled by the House.]

"Mr. Speaker, I move the adoption of this portion of the report as amended."

Motion was seconded and the Speaker called for discussion.

Dr. Samuel M. Day, Duval: "The court case would not necessarily determine this matter of locality. We have another resolution on this subject which, unfortunately, was sent to Reference Committee No. 4, so, therefore, I move that the last portion of the Reference Committee's report, beginning with 'Therefore,' be tabled."

Motion to table was seconded and carried.

Motion was carried to approve the recommendation of the Reference Committee as amended.

Dr. Zellner: "Action No. 24, Florida State Board of Examiners in the Basic Sciences. The subject of Item 24 has been considered in another Reference Committee and, therefore, no recommendation is made concerning this action.

"Action No. 35, Paramedical Personnel. Considerable difference of opinion was expressed as to what constitutes paramedical personnel. Your committee feels that this phrase needs more clarification and definition and, therefore, recommends that this item be referred to the Board of Governors for that purpose.

"Mr. Speaker, I move the adoption of this portion of the report."

Motion was seconded and carried.

Dr. Zellner: "Mr. Speaker, I move the adoption of the entire report of the Board of Governors, as amended, except for those items referred to other Reference Committees."

Motion was seconded and carried.

Report of The Board of Governors

GEORGE S. PALMER, *Chairman*

The Board of Governors held four meetings during the Association's administrative year and one telephone conference. They were held on May 15, 1966, June 7, 1966, September 22-23-24, 1966, January 15, 1967 and April 2, 1967.

The Chairman would like to express the opinion that the Officers, members of the Board of Governors, Council Chairmen and Committee Chairmen have been superb in their interest, activities and accomplishments during this year. It has been a pleasure to be closely associated with all of these fine people and I cannot praise them enough for their outstanding work in behalf of the Association.

Major Activities

Annual Meeting.—The Board of Governors approved the format for the 1967 annual meeting and the scientific program as submitted by the Committee on Scientific Work. A new feature in the form of a socioeconomic pro-

gram has been added to the program this year and it is hoped it will be of benefit to the membership.

Presidents' and Secretaries' Conference.—The Ninth Annual Conference of Presidents and Secretaries of County Medical Societies was held in January 1967 in Orlando. Again this year the purpose of the conference was to orient the officers of the county medical societies regarding major programs and activities of the Association to better enable their programming and implementation at the county level. This year's conference covered the subjects of Scientific Activities; Heart Disease, Cancer and Stroke Regional Programs; State Legislative Program, and Medical Economics. Two workshops were conducted prior to the conference on the subject of the state legislative program and medicine and religion. Attention and interest again this year was excellent.

Financial Statement and Budget.—The Board carefully reviewed the financial statement prepared by the Secretary-Treasurer and the Executive Director, and the Auditor's statement prepared by the Association's certified public accountant for the Association's fiscal year which was the calendar year of 1966. The Association had an income from all sources of $328,965; total expenses incurred were $285,026 for a gross excess of income over expenses of $43,930. The Board approved an annual operating budget for the calendar year 1967 in the amount of $325,000, which included $20,000 for reserve and property amortization. In compliance with the By-Laws, this budget was presented by the Executive Director after consultation with the Secretary-Treasurer; it was reviewed by the Executive Committee and approved by the Board of Governors and was based on an anticipated income of $325,000. Copies of the CPA audit are on file in the Association's office and available for review to members of the Association.

Appointments.—On May 15, 1966 the Board appointed Francis T. Holland, M.D., as an AMA delegate to serve on the Board of Governors; Eugene G. Peek Jr., M.D., as the State Board of Health representative on the Board of Governors; approved appointment of Samuel M. Day, M.D., as the optional member of the Executive Committee and as the Public Relations Officer; reappointed Thad Moseley, M.D., as Editor and accepted the Editor's nomination of John M. Packard, M.D., and Oscar W. Freeman, M.D., as Assistant Editors; reappointed Jack Q. Cleveland, M.D., as the Assistant Editor from the Board of Governors; reappointed the Committee on Research with Karl B. Hanson, M.D., as Chairman; reappointed the subcommittees on Inter-American Relations, Quackery, and Venomous Snake Bite. The Board appointed an Ad Hoc Committee on Medical Technology consisting of the present Committee on Medical Technology plus the Secretaries of the Florida Society of Internal Medicine and the Florida Society of General Practice.

Recognition.—The Board reviewed the nominations received from the county medical societies and selected the recipient for the A. H. Robins Company Award "For Outstanding Community Service by a Physician" to be presented at the first meeting of the House of Delegates, May 11, 1967.

Referrals by House of Delegates

The Board reviewed the following resolutions:—Resolution No. 66-15 on the History of Florida Medical Museum and implemented it by the appointment of the Committee on Archives with the Chairman of the Judicial Council and three members of the St. Johns County Medical Society designated by the President after consultation with the President of the St. Johns County Medical Society. A progress report was presented by James J. DeVito, M.D., Chairman, of St. Augustine, and was reviewed by the Board of Governors at its April 1967 meeting. The Association's Committee had met with the Restoration Committee to assist in planning a Hospital Medical Museum. It is planned to try and outfit a doctor's office on the first floor, and on the second floor to place relics in glass cases and have murals on the wall. This project will run in the neighborhood of $15,000. It is suggested that members of the Association be requested to donate to this project through the Florida Medical Foundation to enable its tax deductibility, and officers of pharmaceutical companies be contacted for sponsorship of specific murals.

Resolution No. 66-26—Free Choice of Billing Method. The Board was of the opinion that the use of the government's SSA form No. 1470 by striking the words "I accept assignment" could be used, or the individual physicians own billing could be acceptable.

Resolution No. 66-27—Medicare Admissions. The Board was of the opinion that this resolution is contrary of the current law and regulations of the Medicare program and is not applicable. The Board respectfully submits the recommendation to the House of Delegates that this resolution could not be implemented.

Resolution No. 66-24—General Practice. The Board implemented this resolution as requested by the House of Delegates with the appointment of Walter W. Sackett, M.D., Chairman.

All other resolutions adopted by the House were referred to the appropriate Council and Committee for implementation. The individual actions are reported in the respective Council reports.

Council and Committee Reports

The Board had the opportunity and the privilege of working closely with the Councils and Committees and in coordinating their activities and implementing the policies of the House of Delegates. The Board on April 2 carefully reviewed and edited all Council and Committee reports to be transmitted to the House of Delegates in the Delegates' Handbook. The complete reports as submitted by the Councils and Committees will be available at the Reference Committee meetings.

Nominations

Certificate of Merit.—Your Board recommends that Warren W. Quillian, M.D., of Coral Gables, be awarded the Association's Certificate of Merit.

Certificate of Appreciation.—Your Board recommends that James N. Patterson, M.D., of Tampa, be awarded the Association's Certificate of Appreciation.

Committee on Membership and Discipline.—As provided for in the By-Laws, the Board of Governors nominates the following physicians for those terms expiring in 1967 and vacancies created by reapportionment of Congressional Districts.

District 1
William C. Roberts, M.D., Panama City 1971

District 3
Samuel M. Day, M.D., Jacksonville 1971

District 5
Frank C. Bone, M.D., Orlando 1971

District 7
Gordon H. McSwain, M.D., Arcadia 1971

District 9
Myrl Spivey, M.D., West Palm Beach 1971

District 10
Miles J. Bielek, M.D., Fort Lauderdale 1971
Russell B. Carson, M.D., Fort Lauderdale 1969

Blue Shield Board of Directors.—The Board of Governors reviewed the nominations for the Blue Shield Board of Directors presented by the Blue Shield Nominating Committee, and from the nominations for each physician directorship the following were chosen:

Medical District "B"
Three Year Term
John S. Stewart, M.D., Fort Myers
Francis C. Coleman, M.D., Tampa

Medical District "D"
Three Year Term
Richard M. Fleming, M.D., Miami
Richard C. Dever, M.D., Miami

At Large
Three Year Term
James T. Cook, Jr., M.D., Marianna
Joseph C. Von Thron, M.D., Cocoa Beach

Warren W. Quillian, M.D., Coral Gables
John M. Packard, M.D., Pensacola

E. R. Dunsford, Jr., M.D., Jacksonville
William M. C. Wilhoit, M.D., Pensacola

The lay members nominated by the Nominating Committee were approved by the Board as follows:

Medical District "D"
Three Year Term
Mitchell Wolfson, Miami

At Large
Three Year Term
Dean C. Houk, St. Petersburg
Arthur Saarinen, Fort Lauderdale

Board Actions of Importance

1. AMA Board of Trustees.—Supported re-election of Homer L. Pearson Jr., M.D., for re-election to the AMA Board of Trustees, to which post he was re-elected; supported the nomination of Edward R. Annis, M.D., to the Board of Trustees, provided it would not jeopardize the election of Dr. Pearson.

2. Fee Schedules.—In compliance with House of Delegates' policy, unanimously agreed that the Association could not enter into any contract, recognize, or approve any fee schedule; authorized signing a contract with the Office of Dependents' Medical Care as negotiated for a one month period, the month of May 1966, to cover the services already rendered under the negotiated contract.

3. Advisory Committee on Independent Laboratories.—Requested the State Board of Health to appoint an Advisory Committee on Independent Laboratories composed of the following individuals:

> The Chairman of the FMA Committee on Medical Technologists; the Chairman of the FMA Committee on Pathology; an actively practicing pathologist who is primarily engaged in operating a laboratory independent of a hospital; a medical technologist director, a non-physician who operates a clinical laboratory; a radiologist who is concerned significantly with nuclear medicine in a laboratory independent of a hospital; the Secretary of the State Board of Medical Examiners or some other member of this examining board.

4. Medicare.—Requested that Blue Shield of Florida, Inc., sign the contract or agreement with the Secretary of Health, Education, and Welfare for the purpose of carrying out the provisions of section 1842 of the Social Security Act providing for the use of carriers to administer Part B of Title XVIII of Public Law 89-97, and if the Federal Government changes the contract in any way that is inimical to the policies of Blue Shield of Florida, Inc., or in any other way jeopardizes the close and compatible relationship between Blue Shield of Florida, Inc., the FMA and the physician-patient relationship, that the contract will be cancelled whenever practical or within 90 days, and that the question of the 90 day cancellation provision or whether to accept a contract without this provision be left to the President of the FMA and the President of Blue Shield.

5. Directory.—Authorized the continued use of IBM in compiling the FMA Directory; that the State Board of Medical Examiners' Rosters not be published in 1967, and that an alphabetical roster be included in the 1968 Directory, if the budget permits.

6. Future Meeting Dates.—Recommend that the 1971 meeting of the FMA be held at the Americana Hotel, Bal Harbour, May 5-9, and the 1972 meeting be held at the Diplomat Hotel, May 3-7, subject to satisfactory facilities and arrangements with the hotels involved; authorized the Executive Director to investigate the possibility of holding the annual meeting at the Fontainebleau Hotel in Miami Beach for 1973 or 1974 and reserve tentative dates for Board approval.

(Left to discretion of Board of Governors)

7. Florida Inter-American Foundation.—Advised the Florida Inter-American Foundation that due to its financial irresponsibility the Foundation has required financial assistance previously and is now again in debt—that the Board suggests the individual members try to obtain sufficient funds from donations to pay this debt; that the Board feels reorganization of the Foundation should take place; that the Florida Medical Association can no longer assume any responsibility for the Florida Inter-American Foundation, that its records should be removed from the FMA office and that the FMA staff should no longer be involved in any manner with the affairs of the Foundation, but that the FMA will continue to provide staff assistance for the Sub-committee on Inter-American Relations.

8. Specialty Societies.—Granted recognition to the Florida Society of Ophthalmology and the Florida Society of Otolaryngology, which replaced the Florida Society of Ophthalmology and Otolaryngology, and approved the change in name of the Florida Health Officers' Society to the Florida Society for Preventive Medicine.

9. Florida Psychiatric Society.—Its recognition by the FMA was placed upon probation in September of 1966 because of going directly to state officials without coordinating this action through the FMA. This Society's recognition was suspended on April 2, 1967 because, although already on probation, its representatives made direct recommendations to the Governor and also planned a meeting in direct conflict with the scheduled meetings of the FMA at the Annual Meeting.

10. Indigent Care Policy.—Clarified the Association's policy on Indigent Care to state that when an individual becomes a ward of the government he is no longer considered an indigent patient.

11. Independent Practitioners.—Requested the Blue Shield Board of Directors to do everything in its power to maintain the position of Pathologists, Radiologists and other physicians as independent practitioners.

12. Medicare Claims Review.—Requested the Blue Shield Board of Directors to advise the FMA of any changes in their determination of usual and customary fees, particularly those demanded by the Federal Government; that the FMA and its component county medical societies establish review committees to handle unusual or protested claims arising from administration of Title XVIII-B as requested by Blue Shield of Florida, Inc.; that any Medicare claims which cannot be adjudicated on the county level be referred to the FMA Committee on Health Insurance for review, and that the State as a whole should be considered in adjudicating medicare fees, the same as was done for Dependents' Medical Care.

13. Fee Schedule Activities.—Authorized the revising and up-dating of the FMA Relative Value Studies at the earliest possible date, requesting the Council on Specialty Medicine to receive all recommendations regarding Relative Values from all specialty groups and after due deliberation, make recommendations to the Fee Schedule Committee. The Board reaffirmed its previous position that there will be no dual fee schedule or dual relative value studies; requested that Blue Shield of Florida, Inc., compile and release to the FMA the product data regarding Prevailing Fee Studies and assist the Association with statistical and IBM service to accomplish the up-dating of the Florida Relative Value Studies; that the use of Relative Value Studies by various specialty groups should in no way bear Florida Medical Association endorsement; granted permission to the Florida Society of Anesthesiologists to use part of the FMA 1962 Relative Value Studies with the provision that copyright credit is given to the Association, and approved the recommendations of the Fee Schedules Committee of April 2, 1967 authorizing the 1964 California Relative Value Studies with some amendments be adopted as an interim guide for a revised FMA Relative Value Study.

14. FLAMPAC.—Approved the District Chairmen of the Florida Medical Political Action Committee as recommended by its President; denied for a member of the FMA staff to work for FLAMPAC, but authorized it may be done by an individual staff member if he wishes on his own time and that educational activities of FLAMPAC be carried on under the auspices of the Legislative Council of the Florida Medical Association; granted financial assistance to FLAMPAC for educational activities.

15. FMA Investment Plan.—Approved the amendment to the FMA Investment Plan which gives additional responsibility to Loomis-Sayles Investment Counsel and Pan American Life Insurance Company and reduces the duties of the First Bank and Trust Company to that of Plan Agent, primarily involved with splitting checks received. Except for Keogh Plan participants, First Bank and Trust Company will continue to serve as Trustees.

16. AMA Reference Committees.—Requested the Delegates to AMA to introduce a resolution that AMA Reference Committees attendance be limited to AMA members.

17. AMA Past Presidents.—Requested the Florida Delegates to AMA to introduce a resolution that Past Presidents of AMA be given full privileges in the AMA House of Delegates.

18. AMA Delegates' Expenses.—Requested the Florida Delegates to the AMA to present a resolution for the AMA to reimburse its delegates for all expenses to attend each meeting of the AMA House of Delegates, and that the time for introducing this resolution be left to the discretion of the delegates.

19. Workmen's Compensation.—The Board of Governors reviewed in detail the past history of the Workmen's Compensation medical fee schedule; the recommendations of the Chairman of the Fee Schedule Committee made to the Industrial Commission in June of 1965 requesting the Commission to up-date the fee schedule; the exchange of correspondence between the Secretary-Treasurer and Presidents of the Florida Medical Association with the Industrial Commission; the attempts of some specialty groups to negotiate directly with the Commission; the actions of the House of Delegates, and other pertinent information.

The Board requested that a Florida Medical Association Committee designated by the President discuss and advise the indicated changes in the billing procedures, the Relative Value Studies and the conversion factor regarding care of Workmen's Compensation patients, and that the FMA be prepared to take necessary legal action to test the validity of the Florida Industrial Commission's interpretation of the Florida Workmen's Compensation statutes in its refusal to pay the usual and customary fees charged by Doctors of Medicine of Florida for the care of patients with industrial injuries.

The Board approved legal assistance, at the discretion of the Executive Committee and legal counsel, to any member of the FMA who may be taken into court by the Florida Industrial Commission for billing the patient or the employer direct.

The Reference Committee added the following policy: We recognize the need for adequate compensation for special medical reports when issued to patients.

20. Crippled Children's Commission.—Requested that the Crippled Children's Commission be advised to utilize the Relative Value Studies with a conversion factor which will pay the physician his usual and customary fee, and that unusual cases be considered on an individual basis.

21. Regional Program for Heart Disease, Cancer and Stroke.—Reviewed the history of the program in Florida; the formation of the Florida Advisory Council for Heart Disease, Cancer and Stroke, Inc.; that the planning grant application submitted to Washington had been disapproved; approved the principle that Florida should be considered as a whole for planning purposes, and the operational programs developed under its jurisdiction, and recommended to the Pensacola educational program that they not affiliate themselves with Louisiana, Mississippi or Alabama until the Florida study has defined regional areas.

22. Florida State Board of Health.—Requested the FMA Council on Legislation and Public Agencies to work toward maintaining the Florida State Board of Health in the new constitution as it is now contained in the present constitution; and, regarding proposed legislation, that the Florida State Board of Health be retained as presently constituted.

23. Florida State Board of Medical Examiners.—Recommended opposition to any proposed legislation which would affect the present integrity of the Florida State Board of Medical Examiners; requested that any amendment to the Medical Practice Act this year be strenuously opposed; that the Association cooperate with other professional organizations in opposing the "Super-Board" for all occupational licensure in the State; that the Executive Director of the State Board of Medical Examiners should, among other qualifications, be a Doctor of Medicine who is, or has been, engaged in the private practice of medicine in Florida, and that it would be desirable if he had served on the Board; requested the Board of Medical Examiners to defer any action on the construction of a building to house the Board, and that, upon the retirement of Dr. Homer Pearson, the Florida State Board of Medical Examiners be moved in the proximity of the Florida State Board of Health and the Florida Medical Association, and that the FMA construct a building on its property for lease to the Florida State Board of Medical Examiners for its headquarters.

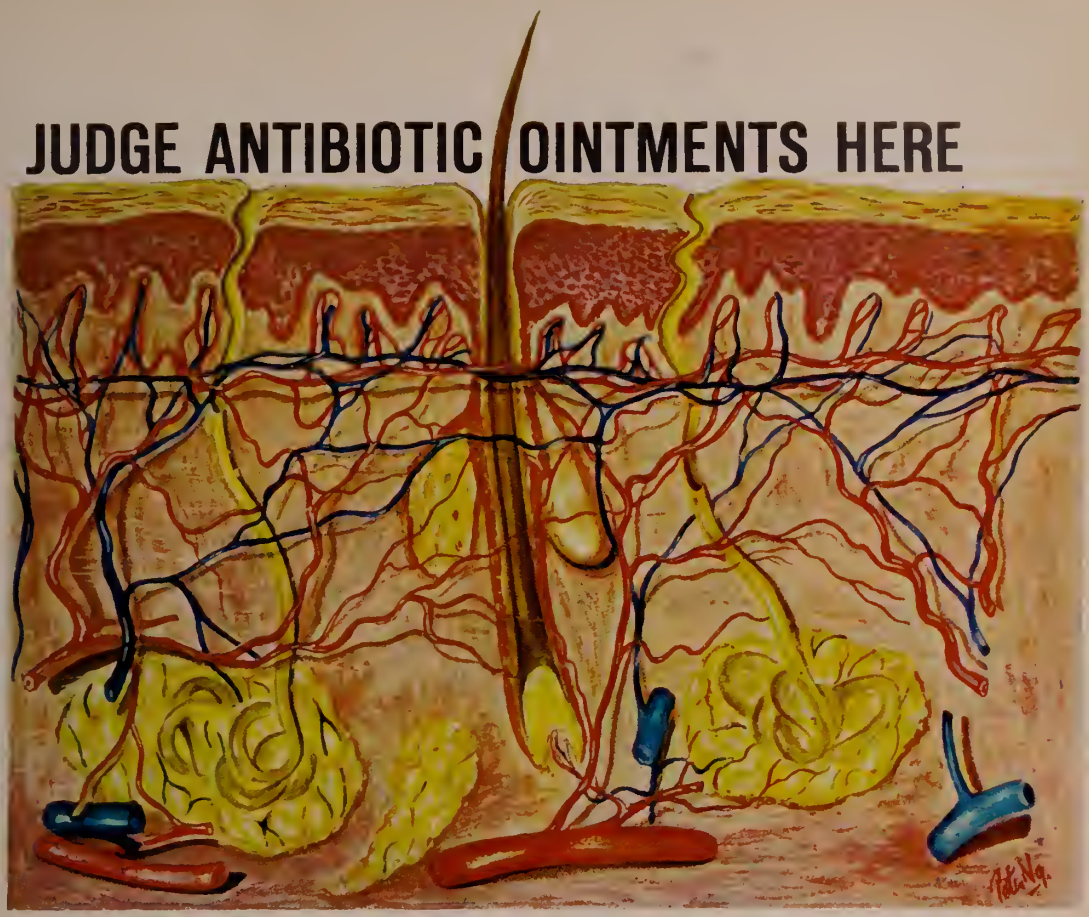
24. Florida State Board of Examiners in the Basic Sciences.—Recommended that the Florida State Board of Examiners in the Basic Sciences be abolished if it seemed that reciprocity would be allowed.

25. Puerto Rico Medical Association.—Met jointly with the Board of Governors of the Puerto Rico Medical Association to discuss mutual problems, programs and activities of the two Associations.

26. Governor-State of Florida.—Approved presentations to the Honorable Claude Kirk, Governor of the State of Florida, of recommendations pertaining to comprehensive health planning, appointment of physicians to

(Continued on page 681)

JUDGE ANTIBIOTIC OINTMENTS HERE



Results on skin are final proof of any topical antibiotic's effectiveness

No in vitro test can duplicate a clinical situation on living skin. 'Neosporin' (polymyxin B—bacitracin—neomycin) Ointment has consistently proven its effectiveness in thousands of cases of bacterial skin infection. The spectra of the three antibiotics overlap in such a way as to provide bactericidal action against most pathogenic bacteria likely to be found topically. Diffusion of the antibiotics from the special petrolatum base is rapid since they are insoluble in the petrolatum, but readily soluble in tissue fluids. The Ointment is bland and nonirritating.

Caution: As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs. Articles in the current medical literature indicate an increase in the prevalence of persons allergic to neomycin. The possibility of such a reaction should be borne in mind.

Contraindications: This product is contraindicated in those individuals who have shown hypersensitivity to any of its components.

Supplied: Tubes of 1 oz., ½ oz. with applicator tip, and ⅛ oz. with ophthalmic tip.

Complete literature available on request from Professional Services Dept. PML.

'NEOSPORIN'®

brand

POLYMYXIN B-BACITRACIN-NEOMYCIN OINTMENT

BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N.Y.

Why these 7 patients with moderate to severe anxiety may respond better to Mellaril



1. The agitated patient.
Anxiety—particularly that beyond th range of minor tranquilizers—fre quently is expressed as gross moto restlessness, fidgetiness and purpose less movements, and may erupt int aggressive behavior. Mellaril is al most a specific for those patient whose anxiety follows such a pattern



The psychosomatic patient.

family physician is rarely given diagnostic luxury of a classic, book "anxiety state." Most often nust probe for anxiety masked by nctional disorder—or which exac-ates a somatic problem. Double-d evaluations have demonstrated Mellaril can be a significant ad-t in the treatment of such patients.



The patient under ational stress.

aril helps the patient deal with ses of everyday life. Nonhabitu-g, it can be given for extended pe-s of time. It does not "separate" patient from practical problems pressures, does not induce eupho-or a fuzziness which can compro-se the ability to cope with reali-ies. Rather, it helps the patient move more competently in his daily world by eliminating use-less tension, by allowing him to conserve emotional resources and energies, and to direct them against the problems really worth worrying about.



4. The menopausal patient.

The woman who sees change of life as the end of useful life requires support from both family and family physician. Whether the psychological impact of menopause is directly related to hormonal changes, or merely coincidental, is debatable, but estrogenic therapy is frequently inadequate. Mellaril is a useful aid for these patients and, alone, or in combination with reduced estrogen dosage, will help ease the menopausal misery.



5. The previously hospitalized psychiatric patient.

Such a patient may still require the type of medication he has been accustomed to, but because he is no longer in a controlled setting the acceptable level of adverse reactions must be lower. In such circumstances Mellaril is perhaps the drug of choice.



6. The agitated geriatric.

Tranquilizer therapy in the elderly patient always involves special (or at least accentuated) problems: the possibility of drug-induced ataxia, hypotension or depression, for example, assumes an additional significance. These reactions have rarely been observed in geriatric patients treated with Mellaril.



7. The constantly returning patient.

The anxiety patient who has not responded to a minor tranquilizer is not very likely to benefit from your minor tranquilizer of second choice. A major tranquilizer, such as Mellaril, may be indicated in such patients.

Contraindications: Severely depressed or comatose states from any cause, and in association with or following MAO inhibitors; severe hypertensive or hypotensive heart disease.

Precautions: Hypersensitivity reactions (e.g., leukopenia, agranulocytosis) and convulsive seizures are infrequent. Pigmentary retinopathy has been observed where doses in excess of those recommended were used for long periods of time. May potentiate central nervous system depressants, atropine, and phosphorus insecticides. Where complete mental alertness is required, administer the drug cautiously and increase dosage gradually. In addition, orthostatic hypotension (especially in female patients) has been observed. Epinephrine should be avoided in treatment of drug-induced hypotension.

Side Effects: Pseudoparkinsonism and other extrapyramidal disorders are infrequent; drowsiness, especially in high doses early in treatment, may occur; nocturnal confusion, dryness of the mouth, nasal stuffiness, headache, peripheral edema, lactation, galactorrhea, and inhibition of ejaculation are noted on occasion; photosensitivity and other allergic skin reactions may occur but are extremely rare.

Before prescribing, see package insert for full product information.

in moderate to severe anxiety, 25 mg. t.i.d.

Mellaril®
(thioridazine)

SANDOZ


Bartholin's gland
Periurethral glands
Cervical glands
Flagyl.....
brand of
metronidazole
Seminal vesicles
Bladder
Prostate gland

Flagyl seeks out the sites where trichomonads hide. Only a systemic agent can. Flagyl does, selectively and effectively.

Flagyl destroys trichomonads in the inner crypts, glands and cavities of the genitourinary tract in both women and men. Consequently, Flagyl is capable not only of curing trichomoniasis in women but also of preventing reinfection.

Correctly used, with due attention to repeat courses of treatment for resistant, deep-seated invasion and to the presumption of reinfection from male consorts, Flagyl has repeatedly produced up to 100 per cent cure in large series of patients.

When the diagnosis of trichomoniasis is positive, Flagyl is positive.

Dosage and Administration — In *women:* one 250-mg. oral tablet three times daily for ten days. A vaginal insert of 500 mg. is available for local therapy when desired. When used, one vaginal insert should be placed high in the vaginal vault each day for ten days; concurrently two oral tablets should be taken daily.
In *men* in whom trichomonads have been demonstrated: one 250-mg. oral tablet twice daily for ten days.

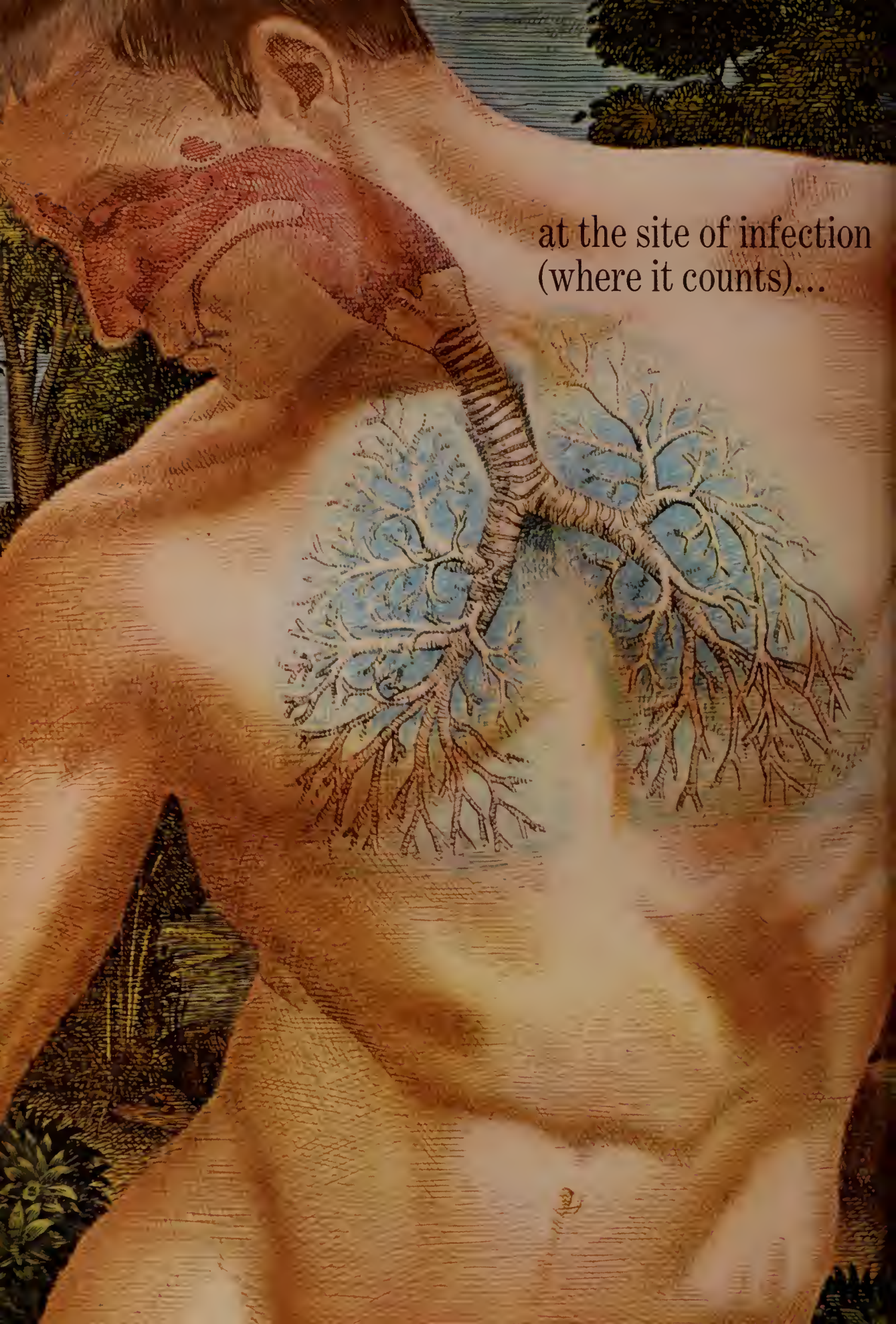
Contraindications — Pregnancy; disease of the central nervous system; evidence or history of blood dyscrasia.

Precaution—Complete blood cell counts should be made before, during and after therapy, especially if a second course is necessary.

Side Effects—Infrequent and minor side effects include nausea, metallic taste, furry tongue and headache. Other effects, all reported in an incidence of less than 1 per cent, are diarrhea, dizziness, vaginal dryness and burning, dry mouth, rash, urticaria, gastritis, drowsiness, insomnia, pruritus, sore tongue, darkened urine, anorexia, vomiting, epigastric distress, dysuria, depression, vertigo, incoordination, ataxia, abdominal cramping, constipation, stomatitis, numbness of an extremity, joint pains, confusion, irritability, weakness, flushing, cystitis, pelvic pressure, dyspareunia, fever, polyuria, incontinence, decreased libido, nasal congestion, proctitis and pyuria. Elimination of trichomonads may aggravate candidiasis.

Destroys Trichomonads Wherever They Are

SEARLE *Research in the Service of Medicine*


at the site of infection
(where it counts)...

Ilosone® provides more antibacterial activity than any other oral erythromycin

Acid stable, better absorbed ... Ilosone produces faster, higher, more prolonged blood levels, even in the presence of food[1-3]

Because it is the most active form of oral erythromycin, Ilosone can help assure consistently greater antibacterial activity at the site of infection. Ilosone produces peak antibacterial blood levels two to four times those of other erythromycin preparations.[1,2] Not only are these levels attained earlier, but they are maintained for much longer periods. Even the presence of food does not seem to affect the activity of Ilosone.[1,3]

In the treatment of patients with bacterial infections susceptible to erythromycin, Ilosone has compiled an excellent therapeutic record. Since it exerts its greatest activity against gram-positive organisms, it is particularly useful in common respiratory and soft-tissue bacterial infections. Ilosone kills—not merely inhibits—streptococci, pneumococci, and more strains of staphylococci than any other macrolide antibiotic. This bactericidal action, coupled with the high antibacterial levels attained, makes Ilosone especially valuable in patients with low host resistance, such as infants, debilitated individuals, and diabetics.

Ilosone has shown no cross-resistance with penicillin and may be effective against organisms that have become resistant to that agent. Despite its high antibacterial activity, Ilosone has demonstrated a low incidence of side reactions. Blood dyscrasias, ototoxicity, and tooth staining have not been observed. Infrequent cases of drug idiosyncrasy, manifested by a cholestatic jaundice, have occurred, but there have been no known definite residual effects.

Now available:
New! Ready-mixed Ilosone Liquid 125! (Contains erythromycin estolate equivalent to 125 mg. erythromycin base per 5-cc. teaspoonful.)

700970

Ilosone®
Erythromycin Estolate

Lilly

(See next page for prescribing information.)

Ilosone®/the most active oral form of erythromycin

scription: Ilosone is the most active form of oral erythromy-
n that has been developed. Because it is stable in acid, well
sorbed, and excreted in lesser amounts in the bile, it provides
ster, higher, and longer-lasting levels of antibacterial activity
BA) in the serum, even when taken with food, than do com-
rable doses of erythromycin.

dications: Ilosone is indicated in infections caused by micro-
ganisms sensitive to its action (especially staphylococci, hemo-
ic streptococci, and pneumococci). The drug is therefore useful
a high proportion of bacterial diseases encountered in clinical
actice and particularly in the treatment of bacterial infections
the upper and lower respiratory tract and soft tissues.

In the treatment of acute bacterial pharyngitis and tonsillitis,
is antibiotic has promptly eradicated the bacteria (streptococci)
d has produced a parallel prompt clinical improvement. There
ve been no group A beta-hemolytic streptococci resistant to
is preparation. In beta-hemolytic streptococcus infections,
eatment should be maintained for ten days to prevent the de-
lopment of rheumatic fever or glomerulonephritis.

Erythromycin estolate has proved to be very effective in pneu-
ococcus pneumonia and in acute bronchitis with pneumococci
culture. Bronchopneumonia and otitis media in children have
sponded well to its use.

The antibiotic has been used very successfully in staphylococ-
s infections. Good therapeutic results have been obtained in
ft-tissue infections, abscesses, cellulitis, carbuncles, wound in-
ctions, and furunculosis.

In serious staphylococcus infections, erythromycin prepara-
ons should be used only in combination therapy with other
timicrobial agents. As is the case with any treatment regimen
ed in these severe conditions, surgical procedures should be
rformed when indicated, and large dosages of the antimicro-
al agents should be employed. In this fashion, Ilosone has been
fective in staphylococcus pneumonia, osteomyelitis, septicemia,
npyema, and meningitis.

Multiple 500-mg. doses of the drug have also been useful in
norrhea and syphilis. Since penicillin is the drug of choice for
e treatment of syphilis and gonorrhea, erythromycin estolate
ould be employed for these infections only in patients with a
story of penicillin allergy. Also, other infections due to suscep-
ble bacteria in patients known to be hypersensitive to penicillin
other antibiotics may be considered for treatment with Ilosone.

ontraindications: Ilosone is contraindicated in patients with a
own history of sensitivity to this drug and in those with pre-
isting liver disease or dysfunction.

dverse Reactions: Data obtained from seven years' use of pro-
onyl erythromycin ester and erythromycin estolate (Ilosone)
dicate that hepatic dysfunction with or without clinical jaun-
ce may occur during or following courses of therapy with the
ug.

Changes in liver function tests in such cases have been indica-
ve of intrahepatic cholestasis. The symptoms appear to be the
sult of a form of sensitization. The initial symptoms have de-
loped in some cases after a few days of treatment but generally
ve followed one or two weeks of continuous therapy or several
urses of the drug. Symptoms reappear promptly, usually within
rty-eight hours, if the drug is readministered to sensitive pa-
nts. Eosinophilia was noted in peripheral blood counts. The
dings readily subsided without apparent residual effects when
eatment was discontinued. Recovery was delayed in one re-
rted instance. The physician indicated in this case that either
ug-induced jaundice or viral hepatitis may have been respon-
ble for the findings.

In one clinical study involving ninety-three patients treated
ith the antibiotic, three cases of jaundice were observed and an
dditional eleven cases developed some changes in liver function
sts. Three of the patients had abnormal liver function tests a
cond time on readministration of the drug.

Even though it is assumed that not all cases of jaundice have
en reported, it seems clear that the number is small compared
ith the amount of drug that has been used. Reported cases have
cluded persons in whom there had been administered other
ugs known to be associated at times with hepatic side-effects
d cases in which the presence of viral hepatitis or other dis-
se may have been responsible for the findings. In some of the
ses, associated gastro-intestinal symptoms simulated the colic
biliary tract disease. In other instances, clinical symptoms
d results of liver function tests resembled findings in extra-
patic obstructive jaundice. It appears that the occurrence of
undice after administration of Ilosone is infrequent, but
rther investigations are being made to estimate its incidence
ore accurately.

In those cases mentioned above in which jaundice appeared to be definitely related to use of the drug, laboratory findings were characterized by increased direct-reacting bilirubin, elevated alkaline phosphatase levels, negative or weakly positive cephalin flocculation and thymol turbidity tests, elevated serum glutamic oxalacetic transaminase levels, peripheral eosinophilia, and normal cholecystograms.

Individual idiosyncrasy seems evident since jaundice has not been reported in other patients taking prolonged courses of the medication. Patients with chronic infection have been given 1 to 2 Gm. of the drug daily for periods of two to six months, and patients with rheumatic fever have taken prophylactic doses of 0.5 Gm. daily for two years without difficulty. In one group of 144 patients who received the drug daily for two years, no jaundice was noted. It was of interest that members of six of these patients' families, who were not taking the drug, had episodes of jaundice during the study period.

Transaminase and serum alkaline phosphatase levels were determined in a group of fifty-four adults and children who took 250 mg. of Ilosone daily for an average of sixteen months as rheumatic fever prophylaxis. The results were compared with those of a similar group of forty-four patients who received penicillin. There were no cases of jaundice in either group. Elevation of SGPT and serum alkaline phosphatase levels during the course of treatment was observed in one patient treated with Ilosone and in two patients treated with penicillin. Seven other patients in the group receiving Ilosone and four others in the penicillin group showed elevations in one of the tests at some time during administration of the drugs.

Very satisfactory therapeutic results, without toxicity, were reported in 102 pediatric patients who received short-term (ten-day) courses of Ilosone in the treatment of streptococcus infections. Results of liver function tests in these patients were comparable to those in a similar control group who had received penicillin.

Gastro-intestinal disturbances not associated with hepatic effects are observed in a small proportion of individuals as a result of a local stimulating effect of the medication on the alimentary tract; however, the normal intestinal gram-negative bacteria flora is not appreciably altered by erythromycin drugs.

Although allergic manifestations are uncommon with the use of erythromycin, there have been occasional reports of urticaria, skin eruptions, and, on rare occasions, anaphylaxis.

Administration and Dosage: Ilosone is administered orally.

Ilosone Pulvules®, Ilosone Liquid 125, Ilosone, 125, for Oral Suspension, Ilosone Drops, Ilosone Chewable Tablets.

For infants and for children under twenty-five pounds of body weight, the usual dosage is 5 mg. per pound every six hours; for children twenty-five to fifty pounds, 125 mg. every six hours. (Tablets Ilosone Chewable should be chewed or crushed and swallowed with water.)

For adults and for children over fifty pounds, the usual dosage of Ilosone is 250 mg. every six hours.

For severe infections, these dosages may be doubled.

When larger doses are indicated, parenteral erythromycin therapy should be considered.

In the treatment of syphilis, the recommended total dosage is 20 to 30 Gm. given in divided doses for a period of ten to fifteen days. Close follow-up of the patient is necessary since erythromycin drugs have not had adequate evaluation in all stages of syphilis. Examinations of spinal fluid are recommended as part of the follow-up therapy.

For gonorrhea, 500 mg. four times a day for four days are recommended. In the treatment of gonorrhea, patients with suspected lesion of syphilis should have a dark-field examination before receiving antibiotics, and monthly serologic tests should be made for a period of three months.

How Supplied: Pulvules Ilosone, Capsules, N.F., 125 and 250 mg. (equivalent to base), in bottles of 24 and 100.

Ilosone Liquid 125, Oral Suspension, U.S.P., 125 mg. (equivalent to base) per 5-cc. teaspoonful, in 60-cc. and pint-size packages.

Ilosone, 125, for Oral Suspension, N.F., 125 mg. (equivalent to base) per 5-cc. teaspoonful, in 60 and 150-cc.-size packages.

Ilosone Drops, 5 mg. (equivalent to base) per drop, in 10-cc.-size packages, with dropper calibrated at 25 and 50 mg.

Tablets Ilosone Chewable, N.F., 125 mg. (equivalent to base) in bottles of 50. [03276]

References: 1. Griffith, R. S., and Black, H. R.: Am. J. M. Sc., *247*:69, 196
2. Griffith, R. S., and Black, H. R.: Antibiotics & Chemother., *12*:398, 196
3. Hirsch, H. A., Pryles, C. V., and Finland, M.: Am. J. M. Sc., *239*:198, 1960.

Additional information available to physicians upon request.
Eli Lilly and Company, Indianapolis, Indiana 46206.

Lilly

7009

State agencies, government financing of medical services being covered under Medical Supervision, and requested him to obtain an advisory opinion from the Supreme Court.

27. Tuberculosis Board.—Recommended that the Tuberculosis Board be retained, but if it is abolished, its functions be incorporated into the Florida State Board of Health.

28. Post Payment for Medical Services. — Requested the Council on Medical Economics to study post-payment plans for medical services possibly to be administered by the FMA.

29. Cardiovascular Screening Program. – Approved the recommendation of the Association's Committee on Public Health to co-sponsor a state-wide cardiovascular screening program in cooperation with the State Board of Health and the Florida Heart Association, providing that implementation be dependent upon the approval of the county medical society.

30. Teenage Alert.—Commended the Broward County Medical Association for its program "Teenage Alert" and referred this matter to the Association's appropriate Committee for consideration and implementation on a state-wide basis.

31. Maternal Health.—Requested the Committee on Maternal Health and the Committee on Child Health to expand current programs on maternal mortality to include perinatal mortality.

32. National Legislation.—Agreed to support Congressman Pepper's recommendation to recognize professional service corporations for income tax purposes, and Senator Smathers' legislation to liberalize the Keogh Act to increase the deductible amount to $5,000.

33. Medical Defense Fund.—Authorized an investigation of the possibility of a Medical Defense Fund (for other than professional liability) to protect the good name of the profession, whether it can be done through the present Association or whether it would have to be a separate corporation to receive voluntary contributions for this purpose.

34. Physical Therapy.—Approved in principle amendments to the Physical Therapy Act as proposed by the officers of the Florida Chapter of the American Physical Therapy Association and approved by the President of the Florida Orthopedic Society.

(Referred back to Board of Governors)

35. Paramedical Personnel.—Approved the proposal of the State Board of Medical Examiners assuming the responsibility for the licensure, regulation and discipline of paramedical personnel.

36. Professional Guild. — Reviewed the status of AMA resolution No. 54 of the June 1966 annual meeting, introduced by the Florida delegates and dealing with professional guilds, which was referred to the AMA Board of Trustees, requesting the AMA to undertake a study of the feasibility of the formation of the professional guild by the AMA, advising on March 10, 1967 that self-employed persons are subject to antimonopoly laws and cannot engage in collective bargaining with respect to compensation for their services. The Board recommended the House of Delegates affirmation of the principles of this resolution with the request that it again be introduced into the AMA House of Delegates and its adoption pursued.

37. Medicare Survey.—Approved the request of the Florida Society of Pathologists to urge Blue Cross to postpone its survey and analysis of services furnished by hospital-based physicians until final disposition of H.R. 5710 in Congress.

38. Public Law 89-97, Title XIX.—Recommended to the House of Delegates continuation of Resolution No. 66-22, to implement Title XIX through an insurance carrier and medical foundation providing for payment of usual and customary fees to be paid to either patient or physician on the basis of the itemized bill, if permitted by federal law.

Recommendations

BY-LAWS—After careful consideration, the Board of Governors recommends to the House of Delegates the following amendments to the current By-Laws of the Florida Medical Association, Inc. These amendments bring about the following alterations in the Association's structure, all of which are designed to keep the organization abreast of changing conditions:

I. Changes the name of the Scientific Council to COUNCIL ON SCIENTIFIC ACTIVITIES; the Advisory Committee to Blue Shield to ADVISORY COMMITTEE TO BLUE SHIELD AND FISCAL INTERMEDIARIES; the Committee on Fee Schedules to COMMITTEE ON RELATIVE VALUE STUDIES; the Committee on Hospitals to COMMITTEE ON HOSPITALS AND EXTENDED CARE FACILITIES, and the Committee on Scientific Work to COMMITTEE ON SCIENTIFIC ASSEMBLIES.

II. Abolishes the Council on Medical Education and Hospitals, the Committee on Military Dependents' Medical Care, the Committee on Physician Placement, the Committee on Internships and Residencies and the Committee on Indigent Care.

III. Transfers the Committee on Occupational Health from the Council on Medical Economics to the Council on Medical Services; the Committee on Medical Schools from the former Council on Medical Education and Hospitals to the new Council on Scientific Activities, and the new Committee on Hospitals and Extended Care Facilities from the former Council on Medical Education and Hospitals to the Council on Medical Economics.

IV. Provides for dues exemption for Associate Members serving obligatory military service. Such exemption already is provided for Active Members.

AMENDMENTS (new additions capitalized)

1. Chapter VIII, Section 1, paragraph 1 be amended to read as follows:

"Directly responsible to and reporting through the Executive Committee to the Board of Governors shall be the following Councils:

1. **Allied Professions and Vocations**
2. **Judicial**
3. **Legislation and Public Agencies**
4. **Medical Economics**
5. **Medical Services**
6. **Scientific ACTIVITIES**
7. **Special Activities**
8. **Specialty Medicine**
9. **Voluntary Health Agencies"**

2. Chapter VIII, Section 3, subsection 4, sentence 2 be amended to read as follows:

"It shall maintain liaison with Blue Shield of Florida, commercial health insurance agencies, HOSPITALS AND EXTENDED CARE FACILITIES."

3. Chapter VIII, Section 3, subsection 5 be deleted and subsections 6 through 10 be renumbered as 5 through 9.

4. Chapter VIII, Section 3, subsection 7 (to be renumbered as 6) be amended to read as follows:

"The COUNCIL ON SCIENTIFIC ACTIVITIES shall direct and supervise activities of the Association which pertain to The Journal and other scientific publications, the schedule and program of all Asso-

ciation meetings, postgraduate education, and all scientific research as directed by the House of Delegates or the Board of Governors. IT SHALL DIRECT AND SUPERVISE THOSE ACTIVITIES OF THE ASSOCIATION WHICH PERTAIN TO MEDICAL EDUCATION IN MEDICAL SCHOOLS AND HOSPITALS. IT SHALL STUDY AND INVESTIGATE ANY ASPECT OF MEDICAL SCHOOL ACTIVITIES AND INTERN AND RESIDENT TRAINING, AND IT SHALL SUBMIT RECOMMENDATIONS TO THE EXECUTIVE COMMITTEE. IT SHALL MAINTAIN LIAISON WITH ALL RECOGNIZED MEDICAL SCHOOLS IN THE STATE OF FLORIDA. It shall report its activities regularly to the Board of Governors through the Executive Committee."

5. Chapter IX, Section 1, paragraph 5 be amended to read as follows:

"THE COUNCIL ON MEDICAL ECONOMICS: Committees on Advisory to Blue Shield AND FISCAL INTERMEDIARIES, Health Insurance, HOSPITALS AND EXTENDED CARE FACILITIES, Members' Insurance, and RELATIVE VALUE STUDIES."

6. Chapter IX, Section 1, paragraph 6 be deleted.

7. Chapter IX, Section 1, paragraph 7 be amended to read as follows:

"THE COUNCIL ON MEDICAL SERVICES: Committees on Aging, Blood, Child Health, Emergency Medical Service, Hearing, Labor, Maternal Health, Mental Health, Mental Retardation, OCCUPATIONAL HEALTH, Public Health, Rural Health and Vision."

8. Chapter IX, Section 1, paragraph 8 be amended to read as follows:

"The COUNCIL ON SCIENTIFIC ACTIVITIES: Committee on the Journal and Other Publications, MEDICAL SCHOOLS, Postgraduate Education, Research, and Scientific ASSEMBLIES."

9. Chapter IX, Section 2, subsection 5 be deleted and subsections 6 through 15 be renumbered as 5 through 14.

10. Chapter IX, Section 2, subsection 15 (to be renumbered as 14), sentence 1 be amended to read as follows:

"Committee on RELATIVE VALUE STUDIES."

11. Chapter IX, Section 3, subsection 1 be amended to read as follows:

"THE Advisory Committee to Blue Shield AND FISCAL INTERMEDIARIES shall serve in an advisory capacity to Blue Shield of Florida and as a reference committee of the Board of Governors for problems pertaining to Blue Shield AND OTHER FISCAL INTERMEDIARIES. It shall when indicated consult with other interested Committees and the Council on Specialty Medicine in the study of fee schedules and medical service contracts."

12. Chapter IX, Section 3, subsection 3 be amended to read as follows:

"The Committee on RELATIVE VALUE STUDIES shall be responsible for the study, development, modification, and necessary negotiations of RELATIVE VALUE STUDIES OR fee schedules accepted or endorsed by the Association. It shall consult with other appropriate Committees and with the Council on Specialty Medicine."

13. Chapter IX, Section 3, subsection 5 be amended to read as follows:

"The Committee on Hospitals AND EXTENDED CARE FACILITIES shall serve as liaison with the Florida Hospital Association AND OTHER HEALTH FACILITY ORGANIZATIONS and shall handle all Association matters which mutually concern hospitals, EXTENDED CARE FACILITIES and physicians."

14. Chapter IX, Section 3, subsections 6, 10 and 12 be deleted and subsections 7 through 9, 11, and 13 through 17 be renumbered as 6 through 14.

15. Chapter IX, Section 3, subsection 15 (to be renumbered as 12), sentence 1 be amended to read as follows:

"The Committee on Scientific ASSEMBLIES shall concern itself with the character and scope of the scientific activities of the Association, including the scientific assemblies, motion picture films, television and radio programs and scientific exhibits."

16. Chapter IX, Section 3, subsection 17 (to be renumbered as 14), sentence 3 be amended to read as follows:

"It shall consult with the Committee on Scientific ASSEMBLIES in coordinating meetings held at the time of the Association's Annual Meeting."

17. Chapter I, Section 2 be amended by adding a new subsection 8 to read as follows:

"8. DOCTORS OF MEDICINE SERVING OBLIGATORY MILITARY SERVICE AS PROVIDED FOR IN CHAPTER X, SECTION 2, SUBSECTION 6."

RESOLUTIONS—Your Board recommends the adoption of Resolutions numbers 67-6 Relative Value Factors (Reference Committee No. 4); 67-12 HEW and Other Third Party Compensation for Physician Reports or Witnesses (Reference Committee No. 4); 67-13 Statement of Policy on Chiropractic (Reference Committee No. 1).

Dr. Zellner: "The Reference Committee considered the report of the Judicial Council and it is approved with the following changes:

"The Reference Committee recommends approval of the Report of the Committee on Archives and approval of the supplemental report with the addition of the names of James L. Borland Sr. of Duval County; Homer L. Pearson Jr. of Dade County, and George W. Morse of Escambia County, all of whom died during the past week.

"Mr. Speaker, I move the adoption of this portion of the report as amended."

Motion seconded and carried.

Dr. Zellner: "The Reference Committee considered the report of the Committee on Medical Licensure and recommends that the two recommendations of the Committee be deleted as Recommendation No. 1 is being considered by Reference Committee No. 4, and Recommendation No. 2 is adequately covered in this Committee's report concerning Board Action No. 35.

"Mr. Speaker, I move the adoption of this portion of the report as amended."

Motion was seconded and carried.

Dr. Zellner: "Mr. Speaker, I move the adoption of the entire report of the Judicial Council, as amended."

Motion seconded and carried.

Judicial Council

JOHN J. CHELEDEN, *Chairman*

Council:

The Judicial Council met on November 19, 1966.

The matter of a contract for Emergency Room Coverage at Broward General Hospital, to which the Council reported three objections to the House of Delegates in 1966, had been referred back to the Judicial Council for implementation. The President of the Broward County Medical Association met with the Council to resolve the objections. The following solutions were agreed upon by the Council:

Objection: 1. Salary should not be guaranteed.

Recommendation:

1. That the provision for a guaranteed salary be deleted from the contract, and that staff members of the emergeny department of the Broward General Hospital be advised to negotiate with the Hospital Annually for adequate remuneration for emergency care of indigent patients in lieu of a salary, subject to the approval annually by the medical staff of the Broward General Hospital and the Broward County Medical Association.

Objection: 2. The billing must be in the name of the individual physician who renders the service; and

3. The method of division of fees among the physicians involved is unsatisfactory.

Recommendation:

2. That, in regard to the second and third items, Broward General Hospital medical staff be allowed to arrange with an association of physicians to manage its Emergency Room Department, who shall send out bills on a billhead with all their names on it for services, provided that the fees collected must go back to this Association of Physicians for their use as they see fit.

The Council considered a case referred to it by the Florida Industrial Commission concerning treatment rendered a Workmen's Compensation patient.

Recommendation:

3. That the Florida Industrial Commission be advised that this case has been considered and there is no indication of unethical practice; that in instances of this kind the physician should be contacted in an effort to resolve the problem before an investigation is begun without his knowledge; and that in the future claims which are purely a matter of fees not be referred to the Judicial Council, but to the appropriate insurance review committee.

Recommendation:

4. That the rules and procedures of the Judicial Council and its committees be amended to provide that in fairness to the membership of the Association, any member involved in a complaint be informed of the complaint at the same time the complaint is referred to the County Medical Society, and before any investigation of the member is begun.

The Council considered an appeal of denial of County Society Membership by a physician. After consulting the County Society and discussing its reasons for refusal to admit the physician to membership, the Council denied the physician's appeal.

The Council considered instances where the membership of two County Medical Societies had fallen below the required number of members (five active members) to retain their charters.

Recommendation:

5. That Franklin-Gulf County Medical Society and Washington-Holmes County Medical Society be advised that they no longer have the required number of active members to retain their charters; that the Judicial Council will be glad to do whatever it can to assist them in bringing their membership back up to the required number; that they have a period of one year to do so; and that if they cannot do so within this time period, their charter will be revoked and they will be assigned to an adjoining County Medical Society for supervision.

(Since this action was taken by the Council, the Washington-Holmes County Medical Society has acquired another member and now has five active members for 1967.)

The Council considered a proposed contract for Emergency Room Coverage at South Miami Hospital. The Council found the following objectionable provision in this contract:

1. The contract guarantees a minimum annual return on this contract.

The Council considered the subject of physicians' statements listing charges for "hospital admission" and agreed that statements should properly read "Hospital Admission Examination."

The Council considered an inquiry from the Dade County Medical Association concerning the ethics of establishing an Academic Enrichment Fund for non-practicing members of the faculty at the University of Miami School of Medicine. An opinion has been requested from the American Medical Association Judicial Council. This subject will be considered further upon receipt of its opinion.

Grievances which were unable to be solved at the County level were considered by the Council at the request of the Chairman at the Grievance Committee.

The following opinions were rendered by the Council in response to inquiries by Association members.

66-1: Relations with Naturopaths and Osteopaths—It is not unethical to see a patient in a nursing home used by naturopaths and osteopaths, provided the physician takes care of his patient and has no professional relations whatsoever with these cult practitioners; and that it is unethical to act as medical director of such a nursing home, as the physician would be supervising the cultists.

66-2: Hospital Staff Appointments for Psychologists—Psychologists should not have staff privileges, but should work under the supervision of a doctor of medicine.

66-3: Surgical Assistants' Fees—The surgeon and the assistant should bill separately for their separate services, and that the Council concurs in the opinion of the Chairman referring the inquirer to Section 7, items 5 and 9, of the opinions and reports of the Judicial Council of the AMA.

66-4: Hospital Privileges for Locum Tenens—A physician serving a locum tenens should be admitted to a hospital staff on the same basis as any other physician.

66-5: Illumination of Physician's Sign—The propriety of the sign is best left to the judgment of the local County Medical Society, provided such a sign is dignified and in good taste; that in certain instances in a poorly lighted street a lighted sign is almost a necessity; but that the lighting should not consist of color or blinking or be brilliantly illuminated.

66-6: Physician Ownership of a Pharmacy—It is not unethical for a physician to own or operate a pharmacy; and that the rental of space by a physician or a group of physicians as a pharmacy should be a fixed one. The inquirer was

referred to Section 7, items 40 and 41 of the Judicial Council Opinions and Reports of the American Medical Association.

66-7: Financing of Initiating a Medical Practice—To repay a lay person borrowed money on an income-sharing basis over a five-year period would be unethical; the hiring of a nonmedical person for a flat straight salary until his investment is repaid would be acceptable, but to repay him on a percentage of net income would be unethical; repayment to another physician for operating capital as a percentage of net income would be unethical; but to repay him a straight amount would be acceptable; and a pension program or bonus, for employees, *not* based on the earnings of the partners would be satisfactory.

66-8: Penalty Charges for Overdue Accounts—In response to an inquiry by the Broward County Medical Association, the following opinion was rendered:

> Section 7, paragraph 16, Charging Penalty for Over-due Accounts, requires no change at this time, as the Council feels it is appropriate. The Council is opposed to any penalty or interest charge being made by physicians in their office for overdue accounts. The Council also concurs in the most recent opinion of the AMA Judicial Council dated November 26, 1966, on this subject.

Committees:

Committee on Archives—During the past year the Archives Committee of the Florida Medical Association has conducted its business by a newsletter, July 28, 1966, and telephone conferences on November 5, 1966 and March 25, 1967.

At the First Meeting of the House of Delegates of the Florida Medical Association in May, we conducted a memorial service for those members of our society who had left us during the preceding year. During this meeting we honored those members who had joined our Association between 1927 and 1931 at a reception and by attaching a memorial ribbon to their name tags. We also photographed them individually as they registered. Similar activities are planned for the 1967 meeting.

We have continued our efforts to acquire biographical data on the membership through the use of the Archives Data Forms and have personally contacted a number of men who have failed to complete their forms. Another historical issue of the Florida Medical Association Journal, August 1966, was produced under our auspices with the support of the Editor, Dr. Thad Moseley, and several members of the society who have an interest in historical writing. We hope to produce a third issue in August of this year. Our project, to accumulate information to permit the writing of the History of Medicine of Florida, continues with the support of the committee members and other members of the society. Funds for the Study of some 15,000 ancient Spanish documents in the libraries of our state were supplied in July of 1966 by the National Library of Medicine. Mr. Luis Arana, a scholar of ancient Spanish, has been employed and has already made considerable in-roads on this mammoth task. Interesting and heretofore unknown information is being turned up gradually.

Acting on a resolution of the 1966 House of Delegates, Dr. James DeVito and his committee have been pursuing the feasibility of establishing a Medical Historical Museum as part of the restoration project in St. Augustine. The Chairman of the Archives Committee has served as a technical advisor for this project and made available what information we currently have. Dr. DeVito has prepared a proposal for action of the Board of Governors in this matter.

The Archives Committee has proposed to the Board of Governors embarking upon a program to install suitable historical markers at sites of significant historical interest in our state. This matter is under advisement by the Board of Governors at this time.

Our Association has lost a number of its valued members during the past year and a list of their names will be included in the delegates' packets.

Supplemental Report Committee on Archives

The Association has lost a number of its fine members during the past year and a list of these names is given below.

January 1966
Ralph F. Shirer Jr.—Pinellas

February 1966
Ralph B. Spires—Walton

April 1966
Beverly H. White—Volusia

May 1966
William J. Ramel—Broward

June 1966
Olen B. Hazen—Alachua
I. Kimbell Hicks—Brevard
Louis A. Spicola—Hillsborough
Rolfe Tainter—Orange
Walter R. Tobin—Dade

July 1966
Fred W. Bencker—Palm Beach
Fred Mathers—Orange

August 1966
Arnold S. Anderson—Pinellas
Edward H. Cowell—Dade
John G. Lester—Polk
Arthur I. Parvey—Duval
Henry D. Solomon Jr.—Pinellas
Alvin J. Wood—Pinellas

September 1966
George R. Crisler—Orange
Clarence L. Fessenden—Orange
Chester H. Murphy—Polk
F. Eugene Whaley—Pinellas

October 1966
Robert C. Flipse—Dade
Ludlow Lambdin—Pinellas
Don J. Royer—Palm Beach
Richard H. Sinden—Pinellas
Frederick J. Waas—Duval

November 1966
S. Ward Fleming—Palm Beach
John A. Hughes—Broward
George W. Richardson—Duval
John B. Woodville Jr.—Pinellas

December 1966
Jack Reiss—Dade

January 1967
Robert M. Alexander—Palm Beach
J. Sturdivant Read—Sarasota
A. Lester Stepner—Dade
Harry Tarr—Dade

February 1967
Jay W. Calhoon—Broward
Fay A. Cameron—Hillsborough
Horace A. Day—Orange
Herbert Y. Glicksman—Palm Beach

March 1967
Henry M. Cook—Hillsborough
Edith M. Corlew—Hillsborough
Charles C. Donegan Jr.—Lee-Hendry
Hewitt Johnston—Orange
Frazier J. Payton—Dade
John A. Pines—Orange
Thomas A. Snow—Alachua
Barzillia R. Waldron—Pinellas

April 1967
Fred D. Bartleson—Lee-Hendry
James P. Daniels—Escambia
James C. Nowling—Palm Beach

May 1967
James L. Borland—Duval
George W. Morse—Escambia
Homer L. Pearson Jr.—Dade

Grievance Committee—Twenty-six complaints against members of the Florida Medical Association were received and referred to the county medical society concerned. Seven complainants appealed to this committee the recommendations made by various local medical society grievance committees. Several of these were impossible to further mediate. The material forwarded to this Committee and the nature of the demands showed most of these were initiated by psychoneurotics. Twenty-five cases, including several submitted in previous years, were closed.

Recommendation:

This committee commends the splendid efforts of local county medical society grievance committees to arrive at satisfactory solutions to problems submitted to them.

It is suggested that county grievance committees act with more dispatch in presenting settlement of grievances, and that a copy of these be forwarded to the headquarters office as soon as possible.

Committee on Medical Licensure—In 1966 the Board of Medical Examiners issued medical licenses to 482 physicians and registered 27 physical therapists. Examination dates were changed from June and November to January and July.

Investigation of charges filed with the Board resulted in hearings and the following action:

1 license revoked (unprofessional conduct in practice of medicine by reason of making and signing medical reports indicating physical examination had been made when in fact only a cursory examination, or no examination was performed; permitting unlicensed physician to practice medicine and surgery at a time when physician was unlicensed due to mental incompetency)

8 licenses suspended for two years with suspension not enforced and physicians placed on probation and required to appear before Board semi-annually (4 narcotic addiction; 2 obtaining narcotics through fraud and deceit and failure to maintain record of narcotics received, administered and dispensed in course of professional practice; 1 prescribing narcotics not in good faith for known addicts solely for purpose of satisfying addiction; 1 immoral and unprofessional conduct)

1 license suspended for one year with suspension not enforced and physician placed on probation (administering preparation containing barbiturate acid derivative without history or examination of patient; container in which preparation delivered did not bear label, date, instructions, name of patient or physician)

1 suspension enforced (violation of terms of probation)

9 probation hearings

1 request for reinstatement of revoked license denied

7 licenses reinstated after hearing at termination of suspension

1 reprimand (aiding unlicensed person to practice medicine by providing blank signed prescriptions)

3 applicants denied permission to take examination after hearing by Board (1 alcohol addiction; 1 alcoholism and narcotic addiction; 1 graduate of osteopath school who later obtained medical degree from California College of Medicine.)

During the year 700 unlicensed physicians employed in Florida hospitals were listed with the Board.

Committee on Membership and Discipline—The Committee worked with the Chairman of the Council and its activities are incorporated into the Council's report.

Dr. Zellner: "The Reference Committee considered the report of the Council on Special Activities and recommends that it be approved as printed in the Handbook.

"Mr. Speaker, I move the adoption of this portion of the report.

Motion seconded and carried.

Council on Special Activities

WARREN W. QUILLIAN, *Chairman*

Council:

There has been no occasion for a special meeting of the Council during the past year. The individual Committees have been available during this period; and a brief summary of their activities is noted below. The Chairman of the Council attended the fall meeting of the Board of Governors by invitation; and was impressed again with the dedicated efforts of this group, and of the various committees in service, to the Florida Medical Association.

Committees:

The Woman's Auxiliary conducted its usual programs of assistance to the Florida Medical Association in state and national legislation; Paramedical Clubs for recruitment of young people into the health professions; a scholarship loan fund for students in medical fields; health problems in rural areas, safety and disaster preparedness.

Two new projects of the Auxiliary are its "Homemaker service" to help in homes when the mother is ill, and "Meals on Wheels and Volunteer Friendly Visitor Training" for persons who are ill, homebound, elderly or who need help with special diets at a price they can afford to pay.

Our Board of Past Presidents represents a group with mature judgment and considerable background of experience in the history and policies of the Florida Medical Association over a long period of years. Annually, the traditional Breakfast is a happy occasion at which, along with reminiscences and renewal of friendships, deliberation is given to suggestions for the good of the organization. In compliance with the By-Laws, Samuel M. Day, M.D., was designated to serve on the Judicial Council.

Activities of the AMA delegates have been reported during the year through the media of the Journals of the FMA and the AMA, with excerpts in the AMA News. All of our delegates attended the Annual Session of the House at Chicago last June, and the Clinical Meeting at Las Vegas in November. The delegation was strengthened by the presence of the President, President-elect, Secretary-Treasurer and the Executive Director of the FMA at these meetings. In addition to our five regular delegates to the AMA House, our Association is officially represented in the Sections on Experimental Medicine and on Pediatrics. During the interim between meetings of the House, policy is determined by the Board of Trustees. Dr. Homer L. Pearson was unanimously re-elected by the House of Delegates to the Board of Trustees at the June meeting of the AMA.

Dr. Zellner: "The Reference Committee considered the report of the Ad Hoc Committee on General Practice and recommends that it be approved as presented.

"Mr. Speaker, I move the adoption of this portion of the report."

Motion was seconded and carried.

Ad Hoc Committee on General Practice

WALTER W. SACKETT JR., *Chairman*

Pursuant to a thrice passed resolution of the House of Delegates the Ad Hoc Committee on General Practice was appointed by the President of FMA in the manner prescribed; namely, the deans of both Medical Schools, two members of the Florida Academy of General Practice and two members of FMA. The first and only meeting was held subsequently on October 30 at FMA headquarters with all six members in attendance. It received reports of the Family Medicine Program at the University of Miami and a discussion of some of the ideas being formulated at the University of Florida. The dearth of students entering general practice was ascribed to a number of factors: 1) Insufficient student exposure to general practice, 2) Student belief of greater prestige and income in the specialties, 3) Failure of the GP to enter into community and educational efforts, 4) The emphasis of medical schools on research and the specialties. Discussion as to the solution of the problem was entered into but terminated by a lack of time.

A subsequent meeting called for January was postponed because of inadequate anticipated attendance. Further consideration of the problem has been deferred until the coming year because of the Committee's desire to watch forthcoming developments in general practice, such as the results from the various programs now in a trial period and the contemplated formation of the Boards in Family Medicine. It is the hope of the Committee to consider concrete recommendations to FMA when these factors become more clearly outlined and if the Committee's existence is continued by the Board of Governors.

Dr. Zellner: "Resolution 67-1, Delegates from Specialty Groups, was carefully considered after hearing considerable testimony both pro and con. The Reference Committee feels that the first three 'Whereases' are erroneous.

"First, the specialty sections of the AMA represent areas of specialty practice, as do members of the Council on Specialty Medicine of this Association at the present time, and do not represent specialty organizations.

"Second, the AMA prescribes qualifications for membership in its various specialty sections, which is a simple declaration by the individual doctor that he practices a certain field of medicine. In contrast, each specialty society in Florida prescribes its own membership requirements, which in some instances exclude large numbers of members of this Association practicing specialty medicine.

"Third, since the By-Laws of this Association provide that the President of the Association must seek the advice of the various specialty societies before making his appointments to the Council on Specialty Medicine, the Reference Committee feels that specialty societies do actually have a voice in the composition of the Council on Specialty Medicine, and, therefore, in the House of Delegates.

"Fourth, any specialty organization may seek introduction of resolutions to the House of Delegates through any delegate or through the member on the Council on Specialty Medicine representing his particular segment of medical practice.

"The Committee feels that the present method of selecting the members of the Council on Specialty Medicine is less cumbersome and provides for better representation than would the proposed change.

"Mr. Speaker, I move that Resolution 67-1 not be adopted."

Motion was seconded.

Dr. John A. Rush Jr., Duval: "I wish to speak against the committee report and for the original resolution. Assuming the committee report is correct and that the first three 'Whereases' are inaccurate, the fourth 'Whereas' is adequate grounds for passing the resolution."

Dr. William M. Straight, Dade: "May I make a statement in favor of the report of the Reference Committee? Another point, any member who wishes to be heard in the House of Delegates has only to take an active interest in his local society and it is quite likely he will be elected a delegate. There isn't much sense, to my way of thinking, in encouraging the specialties to operate outside their county societies; this would encourage a group of specialists to feel they need to take no interest in the county society because they could be heard on the floor of the House of Delegates without the county society."

Motion carried and Resolution 67-1 was not adopted.

Dr. Zellner: "Mr. Speaker, with reference to Resolution 67-7, American Medical Association Winter Meetings, the Reference Committee commends Dr. Burns Dobbins' vigorous support of the salubrious Florida climate and concurs in his feelings that the AMA is always welcome in Florida, in winter or summer.

"I move the adoption of Resolution 67-7."

Motion was seconded and carried.

Resolution 67-7

American Medical Association Winter Meetings Burns A. Dobbins, M.D., AMA Delegates

BE IT RESOLVED, That the FMA introduce the following resolution in the AMA House of Delegates:

"Whereas, The weather in Chicago during the winter months is sometimes inclement, to say the least, and

Whereas, The highly successful National Congress on Socio Economics held in January, 1967, could have been a disaster if it had been scheduled one week later; therefore, be it

RESOLVED, That this House of Delegates of the American Medical Association request the staff to consider areas where the winter climate may be more salubrious than that of Chicago before scheduling national meetings, conferences, symposia, etc., which require the attendance of large numbers of people from all over the United States"; be it further

RESOLVED, That other states having winter climates which fall into the above category be invited to join Florida in co-sponsoring the above resolution.

Dr. Zellner: "Regarding Resolution 67-17, State Fair Exhibit, the Association has a Public Relations Officer who is a member of the Board of Governors. One of his duties is to allocate funds for various public relations activities, including health exhibits at county fairs, which are in the interest of the medical profession. How these funds are spent should be determined by a consideration of the whole picture. Your Reference Committee is not in a position to make a judgment as to the value of health exhibits at county fairs. Therefore, it is recommended that this resolution be referred to the Board of Governors for its consideration and action.

"Mr. Speaker, I move the adoption of this recommendation of the Reference Committee."

Motion was seconded and carried.

Resolution 67-17

State Fair Exhibit Pasco-Hernando-Citrus County Medical Society

(Not Approved—Referred to Board of Governors)

Whereas, There is need for relating factual medical information to the public; and

Whereas, Other healing arts or cultists are constantly displaying misleading and untrue medical information; therefore be it

RESOLVED, That the Florida Medical Association sponsor an exhibit annually at the Florida State Fair which is held in Tampa, Florida.

Dr. Zellner: "In consideration of Resolution 67-26, Coordinated Activities, the sponsor indicated his fear that the present policy of the Association with respect to coordinated activities, which reads as follows:

> 'Statement of Policy.—That recommendations and legislative proposals dealing with health matters by representatives of the Florida Medical Association, its component county medical societies, recognized specialty groups and individual members be cleared through or coordinated with the appropriate officer, council or committee of the FMA,'

could be construed to have the effect of stifling individual differences of opinion. Insofar as the Reference Committee has been able to determine, there has never been an instance where such has been the case. One of the very real problems in the successful consummation of any of the Association's legislative activities has been getting the word to everybody. Your Reference Committee feels that anyone who is asked to give an opinion on any proposed medical legislation should inform himself of what position has been taken by the Association on the issue in question. This does not in any wise mean that he should not be free to express his own personal opinion even though it be at variance with Association policy. Your Committee heard testimony, however, of instances in which representations had been made by members of this Association in opposition to stands taken by the Association simply out of ignorance on the part of the doctor. In the opinion of your Committee, the modification of the present statement of policy as proposed by the Alachua County Medical Society is no improvement on the present policy, except that the sentence, 'Opinions by individual members of the FMA shall be clearly identified as individual opinions,' should be added to the present statement of policy.

"Mr. Speaker, I therefore move that Resolution 67-26 be not approved and that the sentence, 'Opinions by individual members of the Florida Medical Association shall be clearly identified as individual opinions,' be added to our present Statement of Policy."

Motion was carried not to approve Resolution 67-26.

Motion was also carried to add the sentence above to the policy of the Association.

Dr. Zellner: "In consideration of Resolution 67-27, Osteopathy, the AMA Judicial Council Opinions and Reports 1966 was again reviewed. There was found to be no disagreement between the Judicial Council Opinions and the official policy of the Florida Medical Association with regard to Osteopathy. No evidence was offered

to the Reference Committee to indicate the desirability of a change, while at the same time testimony was heard to the effect that the present policy had been very helpful in some county medical societies in their dealings with osteopaths. Your Reference Committee recommends that the previous policy with regard to osteopathy of this House of Delegates as adopted in 1962, 1963 and 1966, be reaffirmed.

"Mr. Speaker, I move that Resolution 67-27, which is contrary to that policy, be not adopted."

Motion was seconded and carried.

Dr. Zellner: "Resolution 67-32, Osteopathic Physicians in Public Hospitals. Your Reference Committee had the opportunity to inspect a bill offered in the Florida Legislature designed to grant osteopaths statutory rights to practice in tax-supported hospitals. Included in the same bill was the tired old provision found almost without exception in every such bill, wherein 'such osteopathic physicians and surgeons may perform such medical and surgical services as are taught and practiced in approved osteopathic schools and hospitals.'

"This Association has taken a forthright stand with respect to its relations with osteopaths, whom we consider cultists rather than fellow practitioners of a scientific healing art. Your Committee refers to the statement adopted by this House in July 1962, reaffirmed in 1963 and 1966, stating that:

> " 'The public looks to doctors of medicine, members of this Association, not only for medical care, but also for accurate information, for guidance on questions relating to health and medicine. Should this Association or its individual members do anything to suggest its approval of cultism or cults or the practice of unscientific medicine, not only would it be a disservice to the public, but it would be a misuse of the public trust.'

"Mr. Speaker, I do not feel this subject needs any further elaboration. I move that Resolution No. 67-32 be not adopted."

Motion seconded and carried.

Dr. Zellner expressed appreciation to the members who appeared before the committee, the members of the committee and its secretary, for their excellent work.

Dr. Zellner: "Mr. Speaker, I move the adoption of this entire report as amended."

Motion was seconded and carried.

Dr. Cook assumed the Chair.

Report of Reference Committee No. 4

Legislation and Miscellaneous

Dr. Russell B. Carson, Chairman: "Mr. Speaker, Mr. President and Members of the House of Delegates:

"The Committee spent from 2:30 until 6:35 p.m. in hearing all those who desired to be heard on matters referred to Reference Committee No. 4.

"The Committee's recommendation on each item will be submitted separately and we request that each item be acted upon separately before proceeding to the next.

"The report of the Council on Legislation and Public Agencies was carefully considered and the following amendments are recommended: Top of page 48, Item 1, in the fourth line of this paragraph, the words 'or patient' be added after the word 'physician' so that this will read:

> 'This change would relieve the beneficiary of first having to pay the physician before the physician or patient can claim payment from the Social Security Administration.'



Reference Committee IV membership included Drs. Russell B. Carson, chm., J. Maxey Dell Jr., Charles Larsen Jr., Vernon B. Astler and Maurice M. Greenfield.

"At the bottom of page 49, under 'Recommendations', the following amendments are recommended:

" '1) That all County Societies and Specialty Groups again be reminded of their responsibilities to support the official policies of the Association as adopted by the House of Delegates, and that any action to the contrary by these components of or specialty groups recognized by the Florida Medical Association warrants appropriate action by the Board of Governors.'

"Recommendation No. 2 should be amended by adding to the third line, after 'medically directed,' the words, 'and which respect the conscience of the individual.'

"The Reference Committee recommends approval of this report with the minor changes mentioned above, and wishes to compliment the Council on Legislation and Public Agencies for its excellent report.

"Mr. Speaker, I move the adoption of this portion of the report, as amended."

Motion was seconded and carried.

Council on Legislation and Public Agencies

JOSEPH C. VON THRON, *Chairman*

Council:

The Council met jointly on two occasions with the Committee on State Legislation, at which time all pending items were carefully considered with resulting recommendations made to the Board of Governors. The Council's activities and recommendations are presented in the reports on the Committee on National Legislation and the Committee on State Legislation.

In further follow-up to our national legislative interest, of recent date our Key Contact Physicians were requested to express the medical profession's views to Congress on H.R. 5710, "Social Security Amendments of 1967," now before the House Ways and Means Committee.

Two important points communicated to our Florida delegation who are members of the House Ways and Means Committee, House Rules Committee and the Senate Finance Committee are:

1) That Title XIX permit payment to be made for physicians' services when an itemized bill is offered either by the physician or the patient at the choice of the physician.
2) That the proposal to include the disabled, below the age of 65, in the Medicare program be not adopted.

Committees:

Committee on National Legislation.—During the past year several important items received Committee consideration and action. Among these items were numerous national legislative bills and/or amendments intended to broaden the extent of benefits under the Medicare Program. Of most importance to medicine is the now pending H.R. 5710, "The Social Security Amendments of 1967." In this regard, the Committee will continue support of the AMA advisory efforts to develop acceptable federal regulations to govern state implementation of the present Medicare law and future amendments. Further comments regarding H.R. 5710 are included in this report.

Following are summary comments regarding other legislation of interest to the medical profession:

I. H.R. 10—Keogh Act Amendments—passed.
II. S-260 The Hart Bill—"Medical Restraint of Trade Act of 1967"—pending.
III. H.R. 15121 and S-3389—This legislative proposal establishes the "Joseph H. Hirshhorn Medical and Scientific Garden."—pending.

Congressional visitation.—On March 15-16 of this year, the FMA Key Contact Physicians again visited with the Florida Congressional Delegation in Washington for liaison purposes and to discuss national legislation of interest to the medical profession as well as legislation of general interest.

As regards the Medicare law, the following proposed amendments as urged by the AMA were discussed with the Congressmen:

1) Eliminate the "receipted bill" requirement of the law and substitute "physician's statement." This change would relieve the beneficiary of first having to pay the physician before the physician or patient can claim payment from the Social Security Administration.

2) Eliminate initial certification requirement which physicians must make indicating that hospitalization or medical treatment is necessary. Many times this item of paper work cannot be completed by the physician until after the emergency of admission to a hospital has occurred. SSA and hospitals agree with this amendment.

3) Eliminate the requirement that all patients applying for extended care (nursing home care) first spend a minimum of three days in a hospital. The AMA believes that to require three days of hospitalization is costing the program untold millions of dollars of unnecessary expense.

Other amendments as suggested by AMA to Title XIX (Medicaid Act) which were also discussed were:

1) Permit physicians, at their option, to bill either the administering state agency or the patient. While it is true that only a few beneficiaries would be in a position to pay the physician and then be reimbursed, physicians do not wish to have the Federal Government take away their right to bill optionally.

2) Permit free choice of physicians and write a requirement into the law that the state cannot tell a patient in which facility he must receive his care.

3) Permit usual and customary fees.

4) Permit, by provision of law, the use of the insurance mechanism for payment of medical charges as in Medicare.

5) Provide that there shall be no discrimination by the Federal Government regarding administrative cost to the states irrespective of what agency the state chooses to administer the program. At present the Federal Government pays 75% only if the state chooses the Welfare Department, only 50% if it chooses the Health Department or some other state agency.

6) Permit the states to establish variable eligibility of welfare recipients depending on the cost of living in different geographical areas within a state, cited as an example—it costs more to live in New York City than it does in up-state New York.

7) Provide for the appointment of a National Advisory Council to counsel with the public assistance officials of H.E.W.

Key Contact Physicians.—The Committee considered the suggestion by AMA to expand the Key Contact Physician Program using select Congressional areas. The suggested change was to have a physician contact in each county of the multiple county districts in order that more local physicians would become more knowledgeable as regards national legislation of interest to physicians. Having considered this matter, it was the consensus of the Committee that the present national Key Contact Physician Program remain unchanged.

State Legislation.—The Committee met twice during the past year at which time attention was directed to items which had been referred by the Board of Governors, House of Delegates and other Councils and Committees of the Association. Based on recommendations of the Committee as approved by the Board of Governors, the specific items adopted as the Association's Legislative Program for the coming session of the Florida Legislature which convenes Tuesday, April 4, 1967 are:

*A. Implementation of Title XIX in the State of Florida does not require further legislation to accomplish implementation, but it is necessary for the Legislature to appropriate state funds adequate to provide recommended health care services.

*B. Therapeutic Abortion, Consent for Autopsy and Establishment of a Commission on Medicolegal Examinations do require introduction and passage of bills.

*C. Emergency Hospitalization for the Mentally Ill legislative proposal as developed by the Interim Legislative Special Sub-committee on Commitment Laws is to be sponsored by the FMA. The intent of the proposed bill is in keeping with the objectives desired by FMA and is very similar to provisions of legislation which failed to pass during the last session.

*Copies of the Association's 1967 Legislative Program, including proposed bills to be introduced with synopsis, were made available and furnished to County Medical Societies and all Specialty Groups. It is important to point out that once the Legislature convenes there will be numerous bills introduced which will be of interest to the medical profession.

Summary comments:—On January 28, 1967, the Committee conducted the Workshop Conference on state legislation, at which time the Association's Legislative Program—"how it works and what is necessary to make it successful"—was presented. The Conference was most successful in that approximately 100 key contact physicians and physician officers of County Medical Societies were in attendance.

County Societies are urged to encourage their membership to make plans to come to Tallahassee during the session for the purpose of observing the activities of the Legislature and to become more closely acquainted with their Legislative Delegation. Visiting physicians are also encouraged to offer assistance in manning the medical dispensary for legislators which is being made available for the first time during the 1967 session.

Recommendations:

1) That all County Societies and Specialty Groups again be reminded of their responsibilities to support the official policies of the Association as adopted by the House of Delegates and that any action to the contrary by these components of or specialty groups recognized by the Florida Medical Association warrants appropriate action by the Board of Governors.

2) That the Florida Medical Association encourage and support family planning programs that are medically directed and which respect the conscience of the individual and that all voluntary and governmental sponsored programs should be coordinated with and made available through public health facilities with medical supervision.

Dr. Carson: "Dr. Edward G. Haskell Jr. was accorded the privilege of the floor in the House of Delegates to make an oral supplemental report on legislative activities currently under consideration by the Legislature presently in session. Included in this supplemental report was consideration of Senate Bill No. 433, a Bill to Define Blood Banking and Transfusion Procedures.

"This matter was discussed before the Reference Committee by Dr. Francis Coleman and it was the opinion of the Reference Committee that the Florida Medical Association should lend its support in the enactment of this proposed bill.

"Mr. Speaker, I move the adoption of this portion of the report."

Motion seconded and carried.

Dr. Carson: "The Report of the Council on Medical Economics, including its committee reports on Advisory to Blue Shield, Fee Schedules, Health Insurance and Members' Insurance were considered as individual committee reports.

"The Chairman of this Council presented to the Reference Committee additional information regarding Item 2 at the top of page 53, dealing with a 'usual and customary' fee contract covering a Big 10 Steel Companies' request for coverage. The Blue Shield Board of Directors requests consideration by the House of Delegates of approval of a 'full-service' program for approximately 180 to 200 employees of Big 10 Steel Companies in Florida. The contract would pay the usual and customary fee, but would not carry a service limit ceiling, as is customary with a 'full-service' program. This is considered an exploratory type contract, therefore, the committee recommends to the House of Delegates that it be favorably considered on that basis.

"In place of the recommendation which appears in bold type on page 55, the Reference Committee offers the following substitute recommendation:

"'The Professional Liability Program of the Florida Medical Association is in sound condition, but broader participation on the part of all FMA members is strongly encouraged to insure the preservation and successful continuity of this program.'

"Mr. Speaker, I move the adoption of this portion of the report as amended."

Motion was seconded and carried.

Council on Medical Economics

JACK A. MaCRIS, *Chairman*

Council:

Your Council Chairman is pleased to report that during the past year several of the Committees under the Council were very active in discharging their responsibilities. The Committees most active were the Committee on Advisory to Blue Shield and the Committee on Health Insurance. Although there were no official meetings of the Committees on Fee Schedules, Members Insurance and Occupational Health, the Council Chairman consulted with the Committee Chairmen on several items pending further Committee recommendation. On several occasions the Council Chairman met with the Committees on Blue Shield and Health Insurance in order to be kept abreast of the Committees' recommendations as submitted to and approved by the Board of Governors. The activities and recommendations as developed by those Committees that were active during the past year are included in the Committee reports. Following are summary comments regarding pending items of continuing interest to the Council.

Courses in Medical Economics in Medical Schools.—In follow-up to the request of the Board of Governors concerning the recommendation of the House of Delegates regarding courses in Medical Economics in Florida's Medical Schools, your Chairman is pleased to report that in this regard the Deans of the two Medical Schools were contacted regarding the feasibility of introducing a course in Medical Economics for the senior medical students at the two medical schools consisting of approximately 6 to 8 one-hour lecture and discussion periods. In expressing the Association's concern in this regard, it was pointed out that the graduating medical student has had little opportunity for exposure to subjects such as medical ethics, interprofessional relationships, responsibility to the hospital and the community, and the role of prepaid medical expenses in the daily commerce of the practice of medicine. A suggested list of topics to be included in the lecture and discussion series are:

1) Two hours: Introduction
 Medical ethics and interprofessional relationships.

2) Medical Organization—County, State, National, and specialty medical societies.

3) Two hours: Prepaid medical expense programs—Blue Cross-Blue Shield, independent insurance companies, Medicare.

4) Hospital Staff Relationships—Medical education programs.

5) Community responsibilities.

6) Becoming established in the community—office organization, and beginning practice.

Similar programs are being successfully used in other medical schools throughout the country, such as the University of Louisville School of Medicine. It is the understanding that a curriculum review study is being conducted. The Deans were advised that the Florida Medical Association is most interested in a trial of such a program and would be most happy to assist in any way possible, such as providing lecturers actively engaged in the private practice of medicine, lecturers representing organized medicine, film strips regarding prepaid medical insurance programs, and in organizational details to minimize additional work on the part of the medical schools' teaching staff.

Committees:

Committee on Advisory to Blue Shield.—The Advisory Committee on Blue Shield met on three occasions during the past year, at which time actions and recommendations were made regarding the following items:

1) Resolution 66-26, "Free Choice of Billing Method" and use of the form, "Attending Physicians Statement".—The Committee discussed the method of direct billing known as the Individual Responsibility Program, as well as the alternative as to taking an assignment under the Medicare Part B program. There was general agreement that several methods of direct billings were satisfactory, but that a Participating Physician in Blue Shield should complete the Blue Shield Doctor's Service Report for his patients who are Blue Shield subscribers.
 It was recommended that participating physicians should continue to use the required Blue Shield Doctor's Service Report form if they are to continue as participating physicians.

2) Blue Shield payments to Pathologists, Radiologists, etc—It was recommended that the report of the Special Ad Hoc Committee on Pathology, chairmaned by Robert E. Zellner, M.D., be approved and further recommended that such recommendations be considered applicable to Pathologists, Radiologists, and other concerned physicians.
 The recommendations contained in the report were:

 a) A restatement of the Blue Shield policy of May 11, 1966.
 ". . . that the Executive Committees of Blue Cross of Florida, Inc., and Blue Shield of Florida, Inc., recommend to their respective Boards of Directors that the plans pay charges in accordance with the contract held by the subscriber for radiology and other special fields where indicated, as billed, either through the hospital or through the physician, with an accounting of funds and appropriate transfer for a one-year period with no increase in total payments for these services for the one-year period."

 b) Where a Pathologist is in independent practice, whether this be in his own office or in a hospital (a lease agreement would qualify), he should be paid for any of his charges in accordance with Blue Shield Liability under its several contracts.

 c) Where a Pathologist has a working agreement with a hospital and bills separately for the professional part of the pathology fee, Blue Shield should pay to him directly the professional part of the fee.

 d) Where a hospital bills for the entire amount of the fee for pathology services, Blue Shield should have no liability.

 e) Insofar as payment of pathology and laboratory service fees are concerned, the same criteria should be applied to the Pathologists with hospital lease agreements as to the Pathologists in private practice; i.e., all services for payment of which Blue Shield is liable should be paid whether personally rendered by the Pathologist or simply bearing the stamp of his approval.

It is suggested that the full report of the Ad Hoc Committee on Pathology, which was approved by the Blue Shield Board of Directors be either printed in the Handbook or made available as an informational report to all FMA Delegates.

"J" Contract Conversion.—The Committee received a report that the Blue Shield Board of Directors at its meeting on August 20, 1966, instructed the staff to cease selling the Type "J" contract and to offer the Type "V" (alternate "J" approved by the FMA House of Delegates at its 1966 meeting) as a substitute or to upgrade and sell at least the Type "K" contract. The Type "V" contract as well as the substitute contract for the Type "F", based on the FMA 1962 Relative Value Studies, have been submitted to the Insurance Commissioner for approval and substitution of this for existing "J" and "F" contracts is expected at an early date (pending approval by the Commissioner).

Complementary Coverage.—The Committee received a report that the Joint Liaison Committee of the Blue Cross and Blue Shield Boards of Directors agreed to provide the same coverage for diagnostic work in a doctor's office as is now provided at the outpatient department of the hospital by the Complementary Coverage program. If the utilization experience of the Complementary Coverage remains good through September, they have agreed to offer this extension of benefits at no increase in cost to the subscriber.

Recommendations and actions approved by the Board of Governors:

1. Complementary coverage changes. It was recommended that the Blue Cross and Blue Shield Boards be requested to:
 a) Delete from Complementary Coverage hospital services for diagnostic studies for outpatients.
 b) Keep the emergency services for physicians as it is now written.
 c) Change the deductible under Complementary Coverage from $100 to $50 and pay 100% of reasonable charges above the 80% now paid under Part B of Medicare.

2. Usual and customary fee contract.—The Committee discussed the possibility of Blue Shield writing a program of benefits for the Big Ten steel companies which would pay for physician services on a nonscheduled, usual and customary basis. This would differ from the usual major medical type contract in that it would mainly cover inhospital care, such as most basic contracts do, and that there would be no deductible or co-insurance features. Following a general discussion of the pros and cons of this type contract, the Committee's feeling was that the Blue Shield New Contract proposal should be brought to the Committee of 17 for their advice with special reference made to the method of determining the usual and customary fee. The suggestion was also made that some income limitation, even though high, should be included in the contract.

3. Dental Service Corporation.—The Committee discussed the possibility of Blue Shield participation in a dental prepayment program. It had previously been suggested that the ideal approach to this type prepayment was for organized dentistry in Florida to form a Dental Service Corporation and that Blue Shield could then consider a contract with the Dental Service Corporation to provide sales and claims administration services for them state-wide. The Committee was advised that Florida State Dental Society does not plan to form a Dental Service Corporation, but has set up the mechanism for approval of dental care insurance programs offered by any insurance carrier and a review mechanism for problem cases. It was the feeling of the Committee that Blue Shield should not write Dental Care coverage until such time as the Florida State Dental Society is willing to undertake some of the risk and responsibility involved in such an insurance program. It was agreed that the Florida Dental Society should be advised of the Committee's consideration of this matter.

New Areas of Coverage.—New areas of coverage such as dental service, drug prepayment, psychiatric care, and home and office care are currently pending further Committee consideration.

Committee on Fee Schedules.—The Committee has held no formal meetings since the meeting of the Board of Governors in September at which time instructions were to resume preparation of a revised and up-dated version of the FMA Relative Value Studies.

Presently the Committee has under consideration for its guidance and direction the following Board of Governors recommendations regarding the FMA Relative Value Studies.

1) That the 1962 Relative Value Studies not be declared obsolete but be revised and up-dated at the earliest possible date, requesting the Council on Specialty Medicine to receive all recommendations regarding the relative values from all specialty groups and after due deliberation make recommendations to the Fee Schedule Committee.

2) That there will be no dual fee schedule or dual relative value studies.

3) That the use of Relative Value Studies by the various specialty groups should in no way bear Florida Medical Association acceptance or endorsement.

Summary comment:

The Chairman has consulted with numerous physicians experienced and knowledgeable as regards Relative Value Studies and proposed methodology for up-dating and revision of such studies. Additional consultation has been with Dr. David Reid, Research Analyst of Blue Shield, who has offered valuable assistance in attempting to prepare computerized Relative Value data derived from fee studies of the Prevailing Fee Survey and other Blue Shield contract data. Currently, the accumulation of useable computer data is still in process. Committee action is planned for an early date after computer data, other proposed schedules and specialty group recommendations can be correlated and digested.

Committee on Health Insurance.—At the time of the September 18, 1966 meeting of the Committee on Health Insurance, attention was given to review and discussion of past Committee activities and responsibilities as regards functions of county medical society insurance review committees. In reviewing the guidelines for establishment of local insurance review committees, it was felt of necessity that the purpose and goals should be re-stated in order that the functions and activities of both the state and county level committees could be better understood and be made more effective. The following recommendations were approved by the FMA Board of Governors:

Purpose.—"The purpose is to insure fair mediation and to create a sound relationship between the physicians of the state of Florida; health insurance industry; and the patient (recipient of health insurance benefits)."

The Committee also considered the type of claims submitted for review by local insurance review committees. It was felt that in many instances the fee in question did not warrant review merely because the concerned carrier claims personnel had stated that "fee appears to be excessive" without indication as to the amount of excessiveness. In order to improve and expedite the administrative processing of claims submitted for review and to avoid further misuse of time and effort on the part of local committees, the Committee approved the following recommendations:

1) That claims submitted for review by commercial health insurance carriers be sent directly to county medical society insurance review committees.

2) That in instances where a claim is submitted for review because it is felt that the fee is excessive, that the criteria for this determination be so stated and afforded to the county medical society insurance review committee.
3) That *all claims* submitted for review be first reviewed by competent medical authority.
4) That a letter be written by the Chairman of the Committee on Health Insurance to all component county medical societies and the Florida Health Insurance Council advising of these changes in procedure.

Committee on Members Insurance.—A summary of the FMA sponsored and endorsed programs are as follows:

The five benefit insurance plans have been reviewed and their support by the membership has shown a continuous growth as so reflected by the following statistical report:

FLORIDA MEDICAL ASSOCIATION INSURANCE PROGRAM STATISTICAL FACTS / AS OF MARCH 13, 1967

PLAN	NUMBER OF PARTICIPANTS
Professional Liability	1800
Personal Umbrella	436
Accidental Death & Dismemberment	273
Catastrophe Hospital Expense	1114
Disability Income Protection	
Short Term Plan	680
Long Term Plan	227
Senior Income Plan	5
Office Overhead Expense	404

Recommendation:

The Professional Liability Program of the Florida Medical Association is in sound condition, but broader participation on the part of all FMA members is strongly encouraged to insure the preservation and successful continuity of this program.

Dr. Carson: "Board of Governors Actions Nos. 2, 13, 19, 20, 22, 27, 28, 32, 34 and 38 were referred to Reference Committee No. 4 for consideration.

"We concur in the actions of the Board of Governors with regard to Action No. 2, Fee Schedules; No. 13, Fee Schedule Activities; No. 20, Crippled Children's Commission; No. 22, Florida State Board of Health; No. 28, Post Payment for Medical Services; No. 32, National Legislation; No. 34, Physical Therapy, and No. 38, Public Law 89-97, Title XIX.

"On Action No. 19, Workmen's Compensation, we approve this action of the Board of Governors and wish to add to this report the policy that we recognize the need for adequate compensation for special medical reports when issued to patients.

"On Action No. 27, Tuberculosis Board, we suggest that this be amended to read: 'Recommended that the Tuberculosis Board be retained, but if it is abolished, its functions be incorporated into the Florida State Board of Health.'

"Mr. Speaker, I move the adoption of this portion of the report as amended."

Motion was seconded.

Dr. H. Phillip Hampton, Hillsborough: "I would like to comment on Item 38, on implementation of Title XIX. In the last part of this statement, I would like to see the words 'on the basis of the paid bill,' changed to 'on the basis of the itemized bill.' I move that this amendment be made."

Motion was seconded and carried.

Dr. Pedro Arroyo Jr., Dade: "Regarding Action No. 34, Physical Therapy, this amendment to the bill among other things states that physical therapy should be redefined to eliminate the term 'direction and supervision by the physician.' This is against the policies of the American Physical Therapy Association and against the policies of the American Medical Association and against the policies of the American Hospital Association, where they specifically state that physical therapy should be under the direction, prescription and supervision of a physician.

"Therefore, I move that this action be reconsidered and it be resolved that we would like physical therapy to remain under the supervision and direction of a physician as set forth in the policies of the organizations listed above."

Dr. Arroyo read a telegram from the Florida Society of Physical Medicine and Rehabilitation, and also a telegram from the Medical Advisory Committee to the Crippled Children's Society opposing Action No. 34 of the Board of Governors.

The Speaker ruled Dr. Arroyo's motion out of order because a motion in direct opposition to the motion on the floor may not be accepted.

Dr. Walter C. Jones, Dade, moved to refer this back to the Board of Governors.

Motion to refer was seconded and carried.

Motion was carried to approve the recommendations of the Reference Committee as amended.

(See Board of Governors Report, page 681)

Dr. Carson: "Resolutions 67-2, 67-4 and 67-28, Certification and Recertification of Medical Necessity, were considered together as all three of these resolutions are similar in principle and content. We approve the purposes and principles of all three, but recommend to the House of Delegates that the wording of Resolution 67-28 by the Duval County Medical Society be adopted.

"Mr. Speaker, I move the adoption of this portion of the report."

Motion was seconded and carried.

Resolution 67-28

Certification of Medical Necessity Duval County Medical Society

(Also for 67-2 and 67-4)

Whereas, The Duval County Medical Society has gone on record as urging that portion of the Medicare Law pertaining to certification and recertification of Medicare patients be rescinded, and

Whereas, The Ways and Means Committee of the House of Representatives has held public hearings on HR 5710, the Social Security Amendments of 1967, and

Whereas, The American Medical Association has testified before this Committee in favor of the removal of the initial certification and requested that the recertification also be deleted, now; therefore be it

RESOLVED, That the Duval County Medical Society requests the Florida Medical Association House of Delegates to commend that American Medical Association and their representatives for their stand and urge them to continue to work to achieve our goal of the elimination of the necessity for certification and recertification of Medicare patients.

Dr. Carson: "Resolution 67-5, 67-9, 67-15 and 67-38, on the Florida Industrial Commission, were considered together. The Reference Committee endorses the principles of all these resolutions, but offers the following substitute resolution:"

Dr. Carson read the substitute resolution.

Dr. Carson: "Mr. Speaker, I move the adoption of this substitute resolution."

Motion was seconded.

Dr. Day, Duval: "I think we are getting right back into the same boat we have been in for the last year. You leave no 'out.' You say negotiate for usual and customary fees in all cases. That leaves the negotiating group nothing to go by if they don't pay usual and customary.

"I would like to make a substitute motion that we adopt the 'Resolveds' of Resolution 67-6 by the Board of Governors." He read these "Resolveds."

Motion was seconded.

Someone from the floor said he did not understand Dr. Day's meaning.

Dr. Day: "It actually means that any insurance company or the Industrial Commission has to have a ceiling somewhere along the line. If they get a bill for $5,000, which someone declares is his usual and customary fee, they are going to question it. I think we have to be practical. We are giving medicine a bad name the way we are insisting on 'usual and customary' fees."

Dr. Daughtry, Dade: "It seems to me we are beginning to go down a road here where everybody else is going to decide what our fee will be. This is in line with what Blue Shield is proposing for Medicare which will come up in a few minutes, but the two are very similar. I think we should not talk about exceptions. Let's talk about what the ordinary doctor does, not the occasional big fee that comes in. I think we have to stick to usual and customary fees and it is easy to find out through all the various areas through which a physician reports his fees what is usual and customary. We should not becloud the issue by talking about the exceptional case."

Dr. Carson: "Our Committee discussed these resolutions at length and it was our feeling that the resolutions introduced presented certain elements which we felt were trying to circumvent the action of the House of Delegates—that is, the adoption of any certain fee schedule as a substitute for the policy which was established very definitely last year of usual and customary. Therefore, it was the desire of your Reference Committee to establish, insofar as possible, a generalization or a general policy under which your Florida Medical Association representatives to Tallahassee could negotiate on the basis of usual and customary fees. This is a negotiation; therefore, we felt we were not establishing either a specific fee schedule or tying the hands of the negotiators. That was our reasoning in the presentation of the substitute resolution."

Dr. Day: "If they won't pay usual and customary, what could the negotiators do?"

Dr. Jere W. Annis, Polk: "The main issue here is between the physician and employer and not between the physician and the insurance company. We are talking about fees that the employer can have paid to him by the insurance company, and this is not really our problem. I would support the Reference Committee, but think they might help Dr. Day with his problem if they could say that this program would be based on 'usual and customary,' which would eliminate the possibility of the $5,000 fee, et cetera. But again, if we deal with the employer who sends the patient to us, he can pay us, and in our case he has been paying us over and above what he is getting from insurance. If this happens to very many people, they are going to see to it that they get insurance to cover their needs and then they will make the necessary arrangements with the insurance companies. This is the main issue—

between us and the employer. I would say it might be advisable to adopt this as it is, but say that this program be based on usual and customary fees. We must stick to this or we have lost the whole show."

Dr. William M. C. Wilhoit, Escambia: "I would encourage you to support the Board of Governors' resolution. For the past year we have had a vacuum. Several years ago we were able to get the Industrial Commission to appoint a medical advisory board to them. I am on that Board, and if there is a fee out of line, these are referred to the advisor in that particular specialty, and usually they pay a fair fee. I think Dr. Day's recommendation is that you need some frame of reference. The Industrial Commission will not deal with anyone except FMA and yet we have no basis on which we can negotiate."

Dr. Robert E. Zellner, Orange: "There are certain things we have to consider as facts of life. As we heard in Blue Shield the other day, Blue Shield pays a claim every two and one half seconds of a working day. These claims are not approved by doctors, sometimes they are high school girls, and they have to have some kind of guide. It would be very nice if we could have a doctor evaluate every claim, but no one that pays very many can do that. As the Industrial Commissioner told us yesterday, $56 million was paid last year. What he said he plans to do is sit down with members of the Florida Medical Association and get some sort of guidelines, and after he has done this, turn it over to the insurance companies for individual negotiations.

"I think we should approve the resolution of the Board of Governors rather than that of the Reference Committee."

Dr. Jack A. MaCris, Pinellas: "I would like to speak in support of the action of the House of Delegates a year ago, in that we not be forced to support fixed fee schedules. I speak in support of the Reference Committee's substitute resolution. The Industrial Commission has a fixed fee schedule by law which it has adopted and which it will continue at its own perogative. The Board of Governors has appointed a committee to encourage the Industrial Commission to increase the fees to a more acceptable level to the physicians, which is, in effect, what we are trying to accomplish this morning. For us to allow the FMA to bargain for a fixed fee schedule on behalf of physicians is to rescind the action of this House a year ago. The committee is empowered to encourage them to improve their fees, which will resolve the problem. With the more favorable environment in the Industrial Commission with the new appointments, I think we can go ahead with this committee and accomplish what we are aiming to do without retracting our official stand."

Dr. J. Maxey Dell Jr., Alachua: "In the Reference Committee meeting, we thought probably Item 13 under the Board of Governors report would take care of what Dr. Day is speaking of. If it doesn't, then I would like to speak for Dr. Day's motion endorsing the action of the Board of Governors. Blue Shield, Medicare and the Industrial Commission are going to have a fee schedule whether you like it or not and I think we should work to get the best fees we can in negotiations with them."

The Speaker called for a vote on Dr. Day's motion, which was to substitute the 'Resolveds' from the Board of Governors Resolution 67-6 for the substitute resolution proposed by the Reference Committee.

Motion carried.

Resolves of Resolution 67-6

RESOLVED, That the Board of Governors of this Association be directed to institute forthwith proceedings to accomplish a satisfactory revision of the F.M.A. Relative Value Studies and the Florida Industrial Commission conversion factor so that it will be adequate to pay the "usual and customary" fee of the great majority of doctors caring for injured workmen; and be it further,

RESOLVED, That this Association offer its facilities in assisting any third party agency to adopt conversion factors for medical allowances commensurate with the probable liability of the third party to those whose bills it is paying; and be it further

RESOLVED, That the House of Delegates reaffirms its position that doctors should charge their usual and customary fees for services in all cases except where in the judgment of the individual doctor he should reduce his fee; and

That the assistance of the Florida Medical Association in the adoption by third parties of schedules of allowances for medical services in no way abrogates or denies this principle.

Dr. Edward G. Haskell Jr., Leon: "There are several members of the Legislature here who must leave soon. There are several items which pertain to our legislative program and I would like to ask that we discuss 67-31 and 67-40 out of order."

Dr. Carson agreed to this change.

Dr. Carson: "After full and complete discussion of Resolution 67-31 on Basic Science Examinations and after calling for an expression of the desires of the large audience in attendance, who almost unanimously approved of the retention of the Basic Science Examinations, the Committee recommends that Resolution 67-31 be ap-

proved, with the recommendation that the necessity for this examining board be studied thoroughly by a committee appointed by the President of the Florida Medical Association, with a report to the next House of Delegates.

"Mr. Speaker, I move the adoption of this resolution, as amended."

Motion seconded.

Dr. Haskell: "This particular bill is now before the Senate and the House. If we wait as long as one week, I can assure you this Basic Science Examining Board will be killed. My suggestion is that this body give a positive direction to retain it at the present time and then we can get this bill held up and study it. I would like to move an amendment after the word 'approved' in line five of the Reference Committee report, 'and that the Florida Medical Association through its appointed representatives seek to have the present legislative bills which eliminate the Basic Science Board killed.' "

Motion seconded.

Dr. Walter W. Sackett, Dade: "I don't think this wording is good—the House and Senate might resent it. I think we should say 'that this Board be continued' and not give them the idea we are still not sure, and then just say 'and this shall be under continued study by the Board of Governors.' "

Dr. Carson: "I think I can speak for the committee, that it was our intent that the bill now under consideration should be killed; that we want to retain the basic science examination as it is, at least until such time as it is proven to be of no value to us."

Dr. Sackett: "I would just like to get that word 'killed' out of there. I offer a substitute amendment, 'that this Board be retained and should be under continuing study by a committee.' "

Motion seconded.

Dr. Fisher: "I would like to offer an amendment that this be phrased that 'the Florida Medical Association House of Delegates goes on record that it strongly recommends for the time being the continuation of the Basic Science Examining Board and that they oppose any legislation at the present time to the contrary."

Dr. Fisher's substitute amendment carried.

Dr. Carson asked whether this retained the recommendation of the committee that the President appoint a committee to study this matter.

The Speaker ruled that this was retained as there was nothing in the amendment to contravene this.

Motion carried to approve the recommendation of the Reference Committee as amended.

Resolution 67-31

Basic Science Examinations
Walter W. Sackett Jr., M.D.

Whereas, There is under consideration in the Florida Legislature a bill to abolish the basic science examinations in medicine, and

Whereas, The Board of Governors of the FMA has already expressed a favorable opinion on such a proposition; therefore, now be it

RESOLVED, That the Florida Medical Association goes on record that it strongly recommends for the time being the continuation of the Basic Science Examining Board and that they oppose any legislation at the present time to the contrary, and further be it

RESOLVED, That this expression of opinion be made available to the Florida State Legislature.

Dr. Carson: "Resolution 67-40, Therapeutic Abortion Bill, by Matthew A. Larkin, M. D. and Edward J. Lauth Jr., M.D. After much consideration and floor discussion with proponents and opponents having adequate time for presenting their views to the committee, the Reference Committee is of the unanimous opinion that Resolution 67-40 should not be approved.

"Mr. Speaker, I move that Resolution 67-40 not be adopted."

Motion was seconded.

Dr. Lauth, Dade: "This issue was not brought to the floor in the 1966 House of Delegates and I feel it germane to bring it up now. I wish to substitute for 67-40 the following resolution . . ."

Dr. Lauth offered a substitute resolution which requested that FMA suspend further action in support of this bill until such time as the constitutionality of the similar law passed in Colorado and its effect upon the reputation of the state could be determined.

Motion was seconded.

Dr. Shelley, St. Johns: "At the Reference Committee many able speakers presented their views for and against this bill, but they all had one thing in common they said, 'Let's disregard the religious angle.' I don't think we should toss out religion. We have seen it tossed out of our schools, we have seen the name of God removed from oaths of officials, we have seen what it is doing to our nation. I would like to stop and review very briefly the history of our nation. I want to say that George Washington and his little ragged army at Valley Forge knelt and prayed to God every day that they would survive and our

nation would win its freedom and they won because of the Christian belief which they held. Abraham Lincoln knelt and prayed that our nation would survive the Civil War. Many other leaders of our nation have prayed. I think religion does play a part. We have seen moral and spiritual decay in our country and I think it would be a blot on the medical profession if we contribute in any way to this moral and spiritual decay."

Dr. Fisher: "I would like to speak in opposition to the motion. The Florida Medical Association last year recommended this therapeutic abortion bill. As a result of this recommendation, they approached several members of the legislature other than physicians, but also including the physicians, and asked them to handle this bill for the Florida Medical Association. I believe we have a definite obligation to reaffirm this and not violate our trust to those members of the legislature who introduced this very 'hot' political issue into the legislature. Secondly, I was glad to see Dr. Lauth offer this substitute resolution, because it is just a delaying action and means we must have pretty good strength at this time. There is another urgency that this legislation pass, because if we take the emotionalism out of the issue, we know that this legislation does nothing more than put on the Florida statute books the practice carried on in every private, non-Catholic hospital in this state. You saw just Thursday morning the front page of the Miami Herald where one of our physicians acting in the accepted medical manner, performing a therapeutic abortion on medical indications, had an unfortunate result, as we all have—those who do surgery—from time to time. And here is this man without the backing of Florida law, but only of medical codes and medical law. This is another good reason not to delay and I recommend that the substitute motion be soundly defeated and then I have an amendment to put on the committee report."

Dr. Ralph W. Jack, Dade: "I wish to speak against the amendment. I don't think Florida needs to sit back and wait to see how things work out in Colorado. We should be positive in our own actions.

"This body last year put its support behind this bill. To change our stand at this time would certainly not give our legislature any idea how the doctors of Florida really feel about this matter."

Dr. Sackett: "I find myself in a very unique position as a member of the same religious persuasion as Dr. Lauth and Dr. Shelley, but I am also a doctor and a legislator. The stand I am taking is that even though this be my belief, I do not feel I can stand in the way of a doctor with education, training and probably moral principles even higher than mine if he feels this is good medical treatment for his patient. I can see no way that I can oppose this bill. In answer to Dr. Shelley's statement that the minority should be respected, I would submit to you that this is not a compulsory law; it is permissive. Any woman who does not want this performed does not have to have it. Those who do not wish to use the law do not have to use it."

Dr. Thomas M. L. Quehl, Pinellas: "I earnestly request the House of Delegates to reaffirm its position in support of the abortion bill and soundly defeat this amendment, and establish Dr. Lauth as the champion of futility."

Dr. Lauth: "I recognize that in this particular gathering I might well be the champion of futility, but I will be heard on this and it is sad that this was not brought to the floor of this House last year. I agree with Dr. Sackett that we should never impose our religious belief on others. There are good and decent moral beliefs on both sides of this question. I submit that it is not necessary to discuss this in this society. We are doctors of very moral beliefs and I respect those who differ with me completely.

"We are, however, talking about two other things. We are talking about a medical problem. There is varied medical opinion as to whether a therapeutic abortion is necessary for strictly medical reasons in today's modern practice. I say there are none, and I say this in concert with a member of the American Medical Association who in speaking before the American College of Surgeons as long ago as 1951 said, 'There are no medical indications for therapeutic abortion today and any doctor who uses them is either ignorant of the advances of medicine or does not wish to use them.'

"But overriding this issue, we are not talking about the life of the mother—we are talking about the health of the mother, mental and physical. The life of the mother rarely comes up today. The law upon the books says 'the life of the mother in jeopardy.' At this time this does not happen, and if it does it is extremely rare, but

it is at least constitutional because it weighs the gravity of one life versus the other. Now we have a proposal where the mother's life is not in danger, only her health, mental or physical, or the health of the baby, mental or physical, and this proposal would deny an innocent person the due process of law. I have read legal briefs, which have yet to be refuted, wherein the law in numerous instances cites the foetus as a person. It does so in torts and wrongful acts; it does so in inheritance cases. In numerous cases, and these are documented, the foetus is a person from the moment of conception. If you allow the taking of this life without due process of law you are violating the Constitution. I submit you should change the Constitution to say 'Life, liberty and the pursuit of happiness and the right to take an innocent life if it interferes with yours.'

'One other final point, doctors have traditionally been for the saving of life. To me there is a gross incongruity to spend nights and days over a premature baby in an incubator and then walk into the operating room and scrape out a foetus, or an embryo, because this bill allows up to 20 weeks.

"Gentlemen, my resolution says to wait on the action in Colorado because of the reflection upon the reputation of the State of Florida. I know there will be an amendment not allowing this to be done on a girl coming into the state, but it still holds up Florida as one of the first to pass a law that would take an innocent life without due process of law and I would urge that further action be suspended."

Motion carried to call for the question.

Motion carried to defeat the substitute resolution.

Dr. Lauth asked if the bill now before the Legislature is defeated, is this action to continue without further discussion before the House of Delegates.

The Speaker ruled this question out of order.

Dr. Fisher asked to add an amendment to the recommendation of the Reference Committee.

Dr. Fisher: "Further, this House goes on record to strongly reaffirm the sponsorship of the Florida Medical Association in the proposed legislation concerning therapeutic abortion, and further, that these remarks be forwarded to those sponsors of the bill in both Senate and House and also to the members of the Judiciary "A" Committee of the Senate which will take this up for consideration Wednesday afternoon."

The amendment was seconded.

Dr. Lauth moved that this amendment be tabled.

Motion to table was seconded, but was defeated by voice vote.

The Speaker then called for a vote on the amendment, and announced that it carried by voice vote. Dr. Fisher asked if the Speaker would announce the number against the amendment, and Dr. Cook said "two."

Dr. Lauth called for a division of the House, and 10 people stood as being against the amendment. Those for the amendment were not counted.

Motion carried to approve the recommendation of the Reference Committee as amended.

Dr. Evans interrupted the proceedings for a moment to thank all the physician members of the legislature and the House gave them a rising vote of thanks.

Dr. Lauth then asked to introduce a resolution to the effect that if the present bill on therapeutic abortion does not pass the legislature, the representatives of the Florida Medical Association take no further action on this subject until a complete review and study has been made and again presented to the House of Delegates.

The Speaker ruled that this motion was out of order as it was a new subject and would have had to be presented to the First House of Delegates.

Dr. Carson: "Resolution No. 67-10 Public Law 89-97, Section 1801, Physical Therapy Patients—The Reference Committee recommends approval of this resolution as presented.

"Mr. Speaker I move the adoption of this portion of the report."

Motion was seconded and carried.

Resolution 67-10

Public Law 89-97, Section 1801 Physical Therapy Patients Leon-Wakulla-Jefferson County Medical Society

Whereas, Public Law 89-97, Title XVIII, Section 1801, prohibits any interference with doctor-patient relationship; and

Whereas, An informational letter from Blue Cross of Florida, under the name of Hugh C. Thomas, Medical Provider, Relationship Representative, Subject: "Physical, Occupational, and Speech Therapy Furnished Beneficiaries Under Medicare Programs, Medicare Part A, Claims Memo 3-67", tends to circumvent this relationship in that this letter states that the physical therapy patient must be referred to a home health agency and they, in turn, will refer the patient to a therapist for treatment *if* they deem this pertinent, and states the therapist must report to the home health agency and not to the physician treating the patient, and further, states that these in-

dividuals are patients of the home health agency and not patients of the therapist or of the individual physician; now, therefore, be it

RESOLVED, That these regulations are contrary to Public Law 89-97, Section 1801, and the regulations thereunto appertaining, No. 405.1229; and be it further

RESOLVED, That this be brought to the attention of Florida Medical Association and the Florida Blue Cross; and be it further

RESOLVED, That the physicians of Florida conform to the Physical Therapy Act of Florida and not refer patients to the home health agency unless they can continue to maintain medical supervision of the patients; and be it further

RESOLVED, That this be forwarded to members of Congress and the American Medical Association.

Dr. Carson: "Resolution 67-41, dealing with Blue Shield's payment for physiatry (physical therapy) service requires further study and clarification and we, therefore, recommend it be referred to the Board of Governors for this purpose.

"Mr. Speaker, I move the adoption of this portion of the report."

Motion was seconded and carried.

Resolution 67-41

Blue Shield
Leon-Wakulla-Jefferson County Medical Society

(Referred to the Board of Governors)

Whereas, Blue Shield under its extended program refuses to pay bills for physical therapy unless the service is actually performed by a physician, and

Whereas, Blue Shield states on page 40 of the new 1967 manual for physicians: "When a subscriber who is a registered bed patient in the hospital receives physiatry services (physical therapy) prescribed by the attending physician and *rendered by* a physician who customarily bills for such services, he is entitled to benefits for each day he receives such services at a rate up to $5.00/day up to a maximum of 31 days - - - .

Physiatry means the treatment of disease or injury by physical means such as massage, hydrotherapy or heat treatments - - - . Although benefits for physiatry are provided only during the period of time a subscriber is eligible for in-hospital medical care, during such period of time they are available in addition to regular in-patient medical care, if the physiatrical services are rendered by and charged for by a physician other than the physician who bills for the in-hospital medical care, and

Whereas, Blue Shield states in its extended benefits brochure under "Out-of-Hospital and Out-of-Hospital Services." #2 "Payment of 80% of the charges for physical therapy services by a participating physician in his office." However, Blue Shield has refused to pay for such services when rendered by a registered physical therapist working in a physicians office, and

Whereas, the professions of physical therapy and physiatry are separate entities. In the State of Florida there are only eight physiatrists; these few could treat only a fraction of the number of patients needing physical therapy. There are approximately 300 physical therapists registered in the state who are working in doctors offices, rehabilitation centers such as Easter Seal and United Cerebral Palsy or self-employed as well in hospitals. This is less than half of the number needed in Florida. Under the present Blue Shield extended benefits, physical therapy to an out-patient must be given by a physician unless the out-patient goes to a hospital department and receives it from a "hospital employee" (#4 Blue Shield Extended Benefits Out-of-Hospital Services). It does not specify that this employee must be a registered physical therapist or work under a registered physical therapist. This is contrary to the Florida Physical Therapy Act, and

Whereas, Florida Statute 486 states that it is unlawful for any person registered under this chapter as a physical therapist to treat human ailments by physical therapy except under prescription, direction and supervision of a person licensed by the state to practice medicine. It is also unlawful for treatment by physical means to be called physical therapy unless given by a registered physical therapist, and

Whereas, The Blue Shield action would appear to be a direct denial of the internationally recognized paramedical profession of physical therapy which operated only under the prescription and direction of licensed M.D.'s, and

Whereas, The payment for manipulative therapy by practitioners only, thereby eliminating rehabilitation centers, registered physical therapists employed by doctors and private departments operated by qualified registered physical therapists will tend to encourage the cultists who are not doctors of medicine but still entitled to collect insurance payments for questionable manipulative procedures, and

Whereas, It would appear that the current Blue Shield rules are a circumvention of meeting the patient's needs for which he has, in good faith, paid premiums, and the physicians do not have sufficient time to directly perform physical therapy nor could they carry out nursing procedures; therefore, be it

RESOLVED, That the Leon-Wakulla-Jefferson County Society bring this problem to the attention of its members, to the Insurance Commission of the State of Florida, the Florida Medical Association, to any and all Blue Shield policy holders who may request the services in question and that negotiations be undertaken with Blue Cross-Blue Shield of Florida to correct this inequity.

Dr. Carson: "The Committee accepts Resolution 67-11, Blue Shield of Florida, from the Orange County Medical Society with perennial appreciation.

"Mr. Speaker, I move the adoption of this portion of the report."

Motion was seconded and carried.

Resolution 67-11

Blue Shield of Florida
Orange County Medical Society

Whereas, The Orange County Medical Society believes that Blue Shield of Florida has the ability to provide the best type of prepaid medical care protection for the citizens of Florida;

Whereas, It is essential that doctors retain control of the practice of medicine, and not lose it to the government, or any other non-medical party; therefore, be it

RESOLVED, That the Orange County Medical Society recommends to the Florida Medical Association that Blue Shield of Florida, Inc., be maintained and strengthened in every way possible; and that individual doctors and county medical societies give the Plan their wholehearted cooperation and support; it is further

RESOLVED, That the resolution be submitted to the House of Delegates of the Florida Medical Association meeting for approval in session at Bal Harbour, May, 1967.

Dr. Carson: "The Reference Committee recommends that Resolution 67-12, HEW and Other

Third Party Compensation for Physician Reports or Witness, be approved as presented.

"Mr. Speaker, I move the adoption of this portion of the report."

Motion was seconded and carried.

Resolution 67-12

HEW and Other Third Party Compensation For Physician Reports or Witness Board of Governors

Whereas physicians are frequently requested by third parties to prepare reports which require research and careful preparation, and

Whereas it is customary for insurance companies, lawyers and others requesting such reports to reimburse the physician for the cost of their preparation, and

Whereas the Department of Health, Education, and Welfare is demanding such reports on claimants for disability benefits under the Social Security Act without proper compensation and with threats of subpoena; now, therefore, be it

RESOLVED, That the House of Delegates of the American Medical Association go on record as deploring acts of government agencies requiring complete medical reports from physicians without proper compensation and requiring physicians to appear as witnesses without proper compensation; and be it further

RESOLVED, That copies of this resolution be sent to the President of the United States, members of the United States House of Representatives, United States Senators and to the Secretary of Health, Education, and Welfare.

Dr. Carson: "Resolution 67-14, Super-Regulatory Board, although the Committee was advised by reliable sources that this bill has been dropped by the 1967 Legislature, the Reference Committee approves in principle the position of this resolution that the issuance, revocation or suspension of medical licensure should remain in the hands of the State Board of Medical Examiners.

"We recommend that this resolution be amended by deleting the last two paragraphs on page 2.

"Mr. Speaker, I move the adoption of this resolution as amended."

Motion was seconded and carried.

Resolution 67-14

Super-Regulatory Board Broward County Medical Association

Whereas, The Broward County Medical Association is interested in the maintenance of the highest standards of proficiency and attainment for the medical profession and the allied professions; and

Whereas, It has come to the attention of this Association that a Subcommittee on Governmental Reorganization of the Florida Legislature has proposed the creation of a Super-Regulatory Board which would become responsible for the issuance of a license to practice medicine in the State of Florida and which would become responsible for the policing and disciplinary action taken against licensed medical doctors for unprofessional conduct; and

Whereas, The Broward County Medical Association is unalterably opposed to the creation or establishment of any regulatory board or agency wherein the ultimate responsibility for the issuance, denial or revocation or suspension of medical licenses should be placed in the hands of medically unoriented or untrained personnel; and

Whereas, The State Board of Medical Examiners has properly and responsibly discharged its duties to the public and to the medical profession in the issuance, denial, suspension and revocation of medical licenses in the State of Florida; and

Whereas, The Broward County Medical Association reaffirms its approval of the medical profession in Florida being regulated and administered by the State Board of Medical Examiners; and

Whereas, The Broward County Medical Association believes the powers and duties of the State Board of Medical Examiners should be strengthened and increased rather than destroyed or diluted by the creation of a super board or agency by which the medical profession in this State would be legally controlled and regulated entirely by laymen; now, therefore, be it

RESOLVED, That the Broward County Medical Association is unalterably opposed to the creation or establishment of any board, agency, officer or commission by which the medical profession in this State and its allied professions would be regulated or administered in any way, and that the State Board of Medical Examiners continue to execute this statutory responsibility; and be it further

RESOLVED, That the Legislature of the State of Florida enact additional legislation authorizing the State Board of Medical Examiners to protect the public in this State against the illegal and unauthorized practice of medicine by granting to the State Board of Medical Examiners the legal power to maintain injunction proceedings against any person or corporation engaged in the illegal or unauthorized practice of medicine.

Dr. Carson: "Resolution 67-20, Individual Responsibility Policy. A great deal of time was spent considering all aspects of this resolution, and the committee wishes to offer a substitute statement. We recommend that all of the 'Whereases' of this resolution be deleted, and the 'Resolveds' be changed to the following statement:

"RESOLVED, That the Florida Medical Association approve the principle of individual responsibility program between physician and patient."

"Mr. Speaker, I move the adoption of this portion of the report as amended."

Dr. Castleberry, Orange: "I am speaking in support of the Reference Committee and wish to add an amendment which I will propose after my comments. Last year the House of Delegates passed a resolution which stated the Florida Medical Association would assist doctors in the preparation of all types of billing forms. This is fine but it needs some type of specific plan to make the program available.

"I would like to amend the reference committee report to add: 'and that a committee be established specifically to develop and manage a

direct billing patient form plan for use by those who wish to use it.'"

Motion was seconded and the amendment carried.

The recommendation of the Reference Committee as amended carried.

Resolution 67-20

Individual Responsibility Policy
St. Lucie-Okeechobee-Martin County Medical Society

RESOLVED, That the Florida Medical Association approve the principle of individual responsibility program between physician and patient, and that a committee be established specifically to develop and manage a direct billing patient form plan for use by those who wish to use it.

Dr. Carson: "Resolution 67-23, Direct Billing, Title XIX, the Reference Committee recommends amendment of this resolution by deleting the third 'Whereas' and changing the 'Resolved' to read:

"RESOLVED, That the Florida Medical Association endorses the principle of direct billing under any Title XIX program, and in all third party situations except service-type contracts issued by Blue Shield."

"Mr. Speaker, I move the adoption of this resolution as amended."

Motion seconded.

Dr. Howard B. Goodrich, Orange: "I am very much in favor of this resolution, but would like to see it strengthened to be sure it gets to the AMA.

"I would like to amend the resolution by adding two 'Whereases:'

"Whereas, without the provision of direct billing the free choice of physician by the patient is limited to those physicians who will accept an assignment of the insurance, and

"Whereas, without the provision of direct billing the insurance carrier set the fee for the service and the usual, customary and reasonable fee is not necessarily considered;

"Now those are the two 'Whereases,' and I would like to add a 'Resolved:'

"and be it further

"RESOLVED, That Title XIX of Public Law 89-97 be amended to permit direct billing of the patient, or that the regulations under which Title XIX is administered be changed to permit direct billing of the patient, and also that state implementations of Title XIX should permit direct billing; and be it further

"RESOLVED, That this resolution be given to a Florida Delegate to the American Medical Association House of Delegates to be proposed for adoption at their next meeting and delegates from the Florida Medical Association be instructed to support actively this resolution."

Motion to amend was seconded.

Dr. Palmer: "This is something that already has been done— is already accomplished; therefore, there is no point in all of these amendments."

Dr. Hampton: "I would like to verify Dr. Palmer's statement. The AMA is aware of this problem and is actively supporting the direct billing concept under Title XIX. We have chosen, however, to use another term which is more acceptable and better understood by the public, and that is, that we favor payment by the government on submission of an itemized bill. If we refer to this as payment of an itemized bill, to either the patient or the doctor, then we will get the idea over better and avoid the connotation that we are demanding cash on the barrelhead."

Motion to amend was defeated.

Motion of the Reference Committee was carried.

Resolution 67-23

Direct Billing—Title XIX
Charlotte County Medical Society

Whereas, The legislature of this state may find it expedient to enact further legislation to adopt and regulate the Title XIX program under Public Law 89-97 in the State of Florida; and

Whereas, Title XIX of Public Law 89-97 is silent on the question of direct billing for physicians' services; and

Whereas, such a program of individual responsibility on the part of the patient and direct billing on the part of the doctor appears to be the only way open to preserve the vital freedom of personal patient-physician relationship in medical practice; therefore, be it

RESOLVED, That the Florida Medical Association endorses the principle of direct billing under any Title XIX program, and in all third party situations except service-type contracts issued by Blue Shield.

Dr. Carson: "On Resolution 67-37, Title XIX, Implementation, your Reference Committee recommends approval as presented.

"Mr. Speaker, I move the adoption of this portion of the report."

Motion was seconded.

Dr. Hampton: "I would like to speak on a point of consistency. We have just previously approved Action 38 of the Board of Governors, and we approved continuation of Resolution 66-22

to implement Title XIX through an insurance carrier and medical foundation providing for payment of usual and customary fees to either patient or physician on the basis of the itemized bill. This resolution would change this previous action quite drastically and would hamper the Board of Governors in their actions to negotiate implementation of Title XIX.

"The Florida law passed in 1965 requires only an appropriation from this Legislature to implement Title XIX and it states that 'it authorizes the provision of medical services to eligible recipients through an agency acting as insuror or fiscal agent.' Therefore, if the Florida legislature makes the appropriation the State Welfare Board will have its choice of either implementing Title XIX, acting as its own insuror and establishing a fee schedule for services rendered, or they may contract out this insurance. It is unlikely however that an insurance company would win the contract with a usual and customary fee. The Board of Governors would not be able to negotiate; therefore, I would ask you to oppose the resolution."

Dr. Carson: "I do not believe the committee intended to negate the action of the Board of Governors. I think, specifically, they wished to disapprove of the 20% reserve, which was accepted as an experiment in the Hillsborough Demonstration Project, and that they did not think the medical profession should be required to underwrite any possible deficit.

Dr. Myrl Spivey, Palm Beach: "I would like to oppose this report. I don't believe we should tie the hands of the Board of Governors in using this 20% as a way of maintaining control of the program, maintaining control of the utilization and maintaining control of the fee structure of this program."

Dr. James A. Winslow, Hillsborough: "This thing is working real well in Hillsborough and certainly we don't want to bind ourselves forever to 20% but neither do we wish to burn the bridges ahead, so I would urge that this be defeated."

Dr. M. Eugene Flipse, Dade: "You can see this is not an experiment—it is already written into the final law. I think we would be better off getting paid our usual and customary fee until the money runs out, then take care of these people for nothing as we always have. They will have the actuarial experience from the Hillsborough project, and I think it is up to the government to appropriate these funds and not ask us to underwrite the program."

The voice vote was not conclusive and a division of the House was necessary. The recommendation of the Reference Committee passed.

Resolution 67-37
Title XIX — Implementation
Dade County Medical Association

Whereas, The Hillsborough County demonstration project for Title XIX in Florida received approval from the FMA for only a limited period of time, and

Whereas, It was intended primarily to obtain actuarial information rather than establish a pattern for implementation of Title XIX; now, therefore, be it

RESOLVED, That the Florida Medical Association disapproves of the 20% "reserve" feature for professional service of the Hillsborough Project as a permanent part of the implementation of Title XIX, and be it further

RESOLVED, That the Florida Medical Association disapproves of any plan for implementation of Title XIX whereby the medical profession might be expected or required to underwrite any possible deficits.

Dr. Carson: "On Resolution 67-21, Blue Shield Service Benefits, your Reference Committee recommends that this resolution be disapproved.

"Mr. Speaker, I move this resolution not be adopted."

Motion seconded and carried.

Dr. Carson: "On Resolution 67-22, Blue Cross-Blue Shield, the Committee recommends that this be approved with the following amendment:

"In the first Resolved, third line, that the words 'appoint a special ad hoc committee,' be changed to read, 'request the Committee on Advisory to Blue Shield.'

"Mr. Speaker, I move the adoption of this resolution as amended."

Motion seconded and carried.

Resolution 67-22
Blue Cross-Blue Shield
Duval County Medical Society

Whereas, Blue Cross of Florida has become the fiscal intermediary for the Social Security Administration for Part A coverage of Title XVIII of Public Law 89-97, and

Whereas, This has seemed to cause an increasing degree of federal control of Blue Cross of Florida policies and actions, and

Whereas, There is concern that Blue Cross of Florida is becoming less responsive to the needs of the patients and their physicians in Florida, and

Whereas, The relationship of Blue Cross of Florida to Blue Shield of Florida is a source of concern; therefore, be it

RESOLVED, That the House of Delegates of the Florida Medical Association request that the president of the Florida Medical Association request the Committee on Advisory to Blue Shield to study the relationships of Blue Cross of Florida with Blue Shield of Florida, and be it further

RESOLVED, That copies of this resolution be forwarded to all county medical societies with a request that they support this resolution.

Dr. Carson: "On Resolution 67-25, Blue Shield, the Committee suggests that this be referred to the Board of Governors with the suggestion that this is a subject for study by the Committee on Advisory to Blue Shield.

"Mr. Speaker, I move the adoption of this portion of the report."

Motion seconded and carried.

Resolution 67-25

Blue Shield
Walter W. Sackett, M.D.

(Not Approved—Referred to Board of Governors)

Whereas, Blue Shield admittedly was in error in advising all holders of Blue Shield policies over 65 to the policy supplementing Medicare, and

Whereas, They implied in these notices to subscribers that this would be the only type of policy they would be allowed to hold after July 1st, 1966, and

Whereas, They agreed to cease and desist as of the Florida Medical Association meeting of 1966 and in spite of this patients continued to feel that they had to change the coverage, and

Whereas, Many subscribers now holding the supplementary policies in some instances to their economic disadvantage, and

Whereas, It is Blue Shield's solemn duty to advise all these subscribers through individual notification and with proper placards introduced that are placed in participating doctors' offices; therefore now be it

RESOLVED, That Blue Shield undertake this project of notification and reinstitution of the subscriber's original policy if he so desires and wishes to change, and further be it

RESOLVED, That the burden of advice to the subscriber on the basis as to which will be the best thing for the policyholder to do shall be placed upon Blue Shield, and finally be it

RESOLVED, The termination date for such a change shall be placed at a reasonable date even up to January 1, 1968.

Dr. Carson: "On Resolution 67-34, Blue Cross Contracts, it is recommended that this be disapproved.

"Mr. Speaker, I move that this resolution not be adopted."

Motion was seconded.

Dr. Scheffel H. Wright, Dade: "I speak in opposition to the Committee's action on this resolution, because I believe the original resolution, as submitted, if implemented by Blue Cross will: 1) eliminate subterfuge in discharge diagnoses; 2) eliminate recurrent dissatisfaction by subscribers with their Blue Cross contracts and their doctors; 3) if an accurate preadmission diagnosis cannot be made, the physician may hesitate to hospitalize to the ultimate detriment of the patient; 4) as a safeguard against 'primarily diagnostic admissions;' these cases can be reviewed by the board of physicians as done at present; 5) the committee by its actions questions the integrity of the admitting physicians, oftentimes; therefore, I move that this portion of the report be disapproved."

The Speaker moved that this motion was out of order, since it was contrary to the motion on the floor.

A voice vote on the motion was inconclusive and a division of the House was necessary, which resulted in a vote to approve the recommendation of the Reference Committee.

Dr. Carson: "On Resolution 67-30, Naturopathy, the committee recommends that this be approved as presented.

"Mr. Speaker, I move the adoption of this portion of the report."

Motion seconded and carried.

Resolution 67-30

Naturopathy
Hillsborough County Medical Association

Whereas, The Hillsborough County Medical Association is an association of ethical physicians dedicated to the practice of scientific medicine and subscribing to the principles of medical ethics of the American Medical Association;

Whereas, Section 10 of these ethical principles states that, "The honored ideals of the medical profession imply that the responsibilities of the physician extend not only to the individual, but also to society where these responsibilities deserve his interest and participation in activities which have the purpose of improving both the health and the well-being of the individual and the community."

Whereas, Senator Joseph A. McClain is introducing in the Senate of the Florida Legislature a bill which will require that the cultists known as *naturopaths* clearly identify themselves to the public as such and no longer be allowed to designate themselves as "doctors" or "physicians;"

Whereas, The purpose of this bill is most laudable and long overdue; therefore, be it

RESOLVED, That the Hillsborough County Medical Association go on record as strongly endorsing this bill and commending Senator McClain for his efforts to see that the citizens of Florida are fully aware of the qualifications of the practitioners from whom they may seek help in illness; and be it further

RESOLVED, That this Association, through its Delegates, do its utmost to cause the Florida Medical Association in its annual meeting next week to take note of this very proper action by Senator McClain and to lend its support in this endeavor.

Dr. Carson: "On Resolution 67-33, Paregoric, after thorough and prolonged discussion of the subject of paregoric, the Committee recommends disapproval of this resolution and retention of the existing regulations governing the sale of paregoric.

"Mr. Speaker, I recommend Resolution 67-33 not be adopted."

Motion seconded and carried.

Dr. Carson: "On Resolution 67-35, Professional Service Corporation, we recommend this be amended by adding in the third line of the first paragraph, after the words 'under the IRS rulings,' the words, 'as it did prior to 1965,' and in the second paragraph, delete the words 'the delegation of the Dade County Medical Association to the,' so this paragraph will read:

" 'RESOLVED, That the Florida Medical Association urge that all possible efforts be made to seek passage of this legislation; and be it further,'

"Mr. Speaker, I move that Resolution 67-35 as amended be adopted."

Motion seconded and carried.

Resolution 67-35

Professional Service Corporations
Dade County Medical Association

Whereas, Legislation is being submitted to the Congress to authorize the Internal Revenue Service to respect state recognized professional associations as corporations under the IRS rulings as it did prior to 1965;
now therefore be it

RESOLVED, That the Florida Medical Association urge that all possible efforts be made to seek passage of this legislation; and be it further

RESOLVED, That a similar resolution be taken to the Annual meeting of the American Medical Association and to other professional national organizations by the AMA, and that a similar resolution be forwarded by the AMA to the medical society of each of the states that have similar laws so that their respective state legislatures may be urged to endorse such federal legislation.

Dr. Carson: "After careful consideration and upon the advice of knowledgeable persons, the Committee recommends that Resolution 67-36, Medicare-Determination of Fees, be disapproved.

"Mr. Speaker, I move that Resolution 67-36 not be adopted."

Motion was seconded.

Dr. Daughtry, Dade: "I would like to make a substitute motion."

He asked that the Resolution be amended by striking the last 'Resolved' and passed in that form.

The Speaker called attention to the fact that discussion of this subject had been tabled previously, and it would be necessary to have a motion to remove it from the table before it could be considered.

Motion carried to remove this from the table.

After some discussion, the substitute motion was defeated.

Motion was carried to approve the recommendation of the Reference Committee.

Dr. Carson: "Resolution 67-39, State Board of Health, the Committee recommends approval of this resolution with the following addition to be inserted in the next to the last paragraph:

"That the Bureau of Narcotics, because of the nature of its duties and responsibilities, remain in the State Board of Health.

"Mr. Speaker, I move the adoption of this resolution as amended."

Motion was seconded and carried.

Resolution 67-39

State Board of Health
Dade County Medical Association

Whereas, the Florida Medical Association is deeply committed to the promotion and preservation of the health of the people of Florida, and

Whereas, on these health matters in which the State Government is involved, The Florida Medical Association is committed, obligated and qualified to give advice and assistance, and

Whereas, the Florida State Board of Health has been established for more than 75 years under the State Constitution and Statutes as the Health Agency of the State, and, under the direction and guidance of a Board made up of physicians and other health professions, has carried out its mission in a capable and honorable manner during this period; therefore be it

RESOLVED, That the Florida Medical Association urges the retention of a definite provision for a State Board of Health in any new State Constitution, not only by name, but specifying the agency's duties and responsibilities.

That the laws continue to provide that the policy guidance of the State Board of Health be given by a Board made up of a majority of physicians and representatives of other health professions.

That it deplores efforts and trends to fragment state and local health programs through the establishment of a multitude of other health agencies, and by the transfer of health functions from the State Board of Health to non-health agencies.

That the Florida Medical Association specifically reaffirms its position that the principal responsibility for the sanitary inspection of food service establishments should remain with the State Board of Health and county health departments.

That air and water pollution represent threats to human health, and programs for the control of these should remain under the State Board of Health.

That the Bureau of Narcotics, because of the nature of its duties and responsibilities, remain in the State Board of Health; therefore be it further

RESOLVED, That copies of this Resolution be made available to the Governor and the Cabinet and the members of the legislature now in session.

Dr. Carson: "Mr. Chairman, the Chairman would like the privilege of adding to the report."

Dr. Cook: "You may."

Dr. Carson: "I would like to add an expression of the Chairman and all of the members of appreciation to the large audience who remained for approximately four hours and for the excellent demeanor they showed in their debate."

Dr. Carson also thanked the individual members of his committee and its secretary, for their long hours of work.

Dr. Carson: "Mr. Speaker, I move the adoption of the entire report as amended."

Motion seconded and carried.

Dr. Evans resumed the Chair and stated that this House had already established three records —the most resolutions introduced, the most oratory and the most members of one family.

The Speaker changed the order of business and called for election of officers.

Dr. Donald F. Marion, Dade: "Mr. Speaker, Mr President and Members:

"The presidency of any professional society is an office which serves a two-fold purpose. By far the more important of these is the opportunity for ultimate and maximal service to the members of the society and to all people who may benefit from the activities of the society. The less important purpose of this highest office is that of recognition of an individual's superior capacity to serve and to honor him for past services. In our Association, we have been blessed for 93 years by an ample supply of such men, and it is largely because of this fortuitous circumstance that the record of service of the Florida Medical Association provides us so much satisfaction and pride.

"This year is no exception. The man I am privileged to nominate for this office is a worthy successor to his illustrious predecessors. Born in North Georgia in 1907, his Bachelor of Science degree was conferred by Emory University in 1926 and his M.D. was received from the same University in 1931. Lest any mathematician wonder about the five year interval between the granting of these degrees, I must explain that he taught school in Moultrie, Georgia from 1928 to 1929. He interned at Grady and served three years as a medical resident at Jackson Memorial in Miami. He has practiced in Coral Gables and Miami ever since, with the exception of four adventurous years with the Air Force Medical Department. In 1942 he was assigned to Morrison Field at West Palm Beach. It required 18 months for those of higher rank and authority to realize he was luxuriating only 70 miles from home. They promptly rectified this deplorable situation and sent him to Australia. He subsequently served in New Guinea and India before receiving his commendations and discharge and returning to his practice in 1946.

"Among his many services to medicine, those rendered to his county and state societies are outstanding. He became DCMA Secretary in 1947 and after yeoman service on virtually every DCMA committee was honored by the presidency in 1951. He has served in the FMA House of Delegates continuously since 1947 and was chairman of the Education and Hospitals Committee for five years. He has been a member of the Board of Governors for the past four years.

"Greatly beloved by his patients and friends, he served two terms as chairman of the Medical Board of Doctors Hospital in Coral Gables. He has contributed greatly to the programs and the growth of the First Methodist Church of Coral Gables, and has served its ministers as personal physician. He has contributed significantly to the growth and development of the Riviera Country Club in Coral Gables where he is a constant source of envy and admiration for his unbelievably high golf handicap.

"His greatest pride and joy, naturally enough, is his wonderful family. His daughter, Lyn, is a lovely sophomore at Emory and his son, John Junior, is an intern at Grady—just as his daddy was some years ago. His beautiful wife, Evelyn, follows in the unbroken tradition of great men's wives. Without wives like Evelyn men just couldn't become great.

"I am humble and grateful for the honor of nominating Jack Cleveland for President of the Florida Medical Association."

Dr. Robert E. Zellner, Orange: "In the 93 years of this Association on only two previous occasions has one family provided us with more than one of its members as president. You have all met some of the Palmer family this time, and you have heard of his father and grandfather, of whom we are very proud. They are from North Florida. Central Florida provided us with Dr. John McEwan, his brother-in-law, Dr. Gaston Edwards and his nephew, Dr. Duncan McEwan, all three of whom practiced in the same office, which I believe is a distinction. Now, South Florida is offering us a second son of a very distinguished family, and I believe they are unusual in this respect—seated in this House are four members of this family and one more member of this Association. You have heard the qualifications of Dr. Cleveland and I won't elaborate upon them except in one respect. I don't think there is anywhere you get to know a man better than on the golf course and hunting with

him, and it has been my privilege to participate in both of these activities with Dr. Jack Cleveland. He is the only man I ever knew who could hunt wild turkey and lost golf balls at the same time. So, it is my privilege to second the nomination of my friend, Jack Cleveland."

The nomination was also seconded by Dr. Russell B. Carson of Broward, Dr. H. Phillip Hampton of Hillsborough, Dr. Samuel M. Day of Duval, Dr. Francis H. Langley of Pinellas, Dr. William C. Roberts of Bay and Dr. Francis T. Holland of Leon, who also moved that nominations be closed and the secretary be instructed to cast a unanimous ballot for Dr. Cleveland. Motion was seconded.

The Speaker announced that Dr. Jack Q. Cleveland was elected President-Elect.

Dr. Donald F. Marion and Dr. Maurice M. Greenfield escorted Dr. Cleveland to the rostrum.

Dr. Cleveland: "This is one time words almost fail me, but not quite. After this parade of talent in the nominations, this is a little anticlimactic. I do appreciate your electing a man from the disaster area of our state; however, I hope this doesn't portend that this will be a disastrous administration next year. Maybe it will rain before my term of office.

"I deeply appreciate this greatest honor I have ever had. When my time comes, it will require your help constantly and I am sure I will have it.

"I do wish my two children were here. I was carried away with Warren's response on his receipt of the Certificate of Merit, and Warren knows me well enough to know I could not let him give a limerick or doggerel without responding. Speaking of this bucket of water:

> "Put your hand in a bucket of water
> And see what you can find,
> It may be a pearl of wisdom,
> Bring it out and keep it in mind.

"Thank you so much for this honor and I will do my best never to let anyone in the Florida Medical Association down. Thank you again."

The House stood in respect to Dr. Cleveland.

The Speaker called for nominations for the office of Vice President.

Dr. Frederick C. Andrews, Lake: "Mr. Speaker, Mr. President, Fellow Delegates:

"It is with great pride that I, as a delegate from Lake County, stand here to nominate for Vice President of the Florida Medical Association one of the leading citizens of Lake County, an outstanding physician, writer, speaker, predictor and flyer. The man whom I will nominate was born on a mountain top in Tennessee and there he learned many things, I assume by his pappy's knee. By the time he was 23, he came out of the hills and worked his way through college by selling Bibles from door to door. This probably gave him his deep understanding of values in maintaining our freedom of choice and preservation of individual rights.

"In 1937 he graduated from the University of Tennessee Medical School. He served in World War II, rising to Air Force Colonel. Following the War, he has been active in medicine in Lake County, where he has served our society as president, secretary-treasurer for seven years and has been our delegate to the FMA for many years. He has served us well and actively; he has served in the FMA as chairman of the Committee on Rural Health, vice chairman of the Committee on Child Health and has served on the School Health Medical Advisory Committee to the State Department of Education and State Board of Health. He has been a representative from the Florida Committee on Rural Health and Chairman of its sub-committee on Medicare and Insurance. He is an active participant in FLAMPAC.



Dr. Jack Q. Cleveland of Coral Gables addresses the House of Delegates following his selection as President-Elect.

"Dr. J. Basil Hall is well versed in organized medicine and is dedicated to the principles of private practice and should be our next Vice President of the Florida Medical Association. I hereby wish to present the name of J. B. Hall for Vice President of the Florida Medical Association."

Dr. John M. Butcher, Sarasota: "Mr. Speaker, the Sarasota delegation is presenting the name of Dr. Irving E. Hall Jr. of our adjoining county, Manatee, for the office of Vice President of the Florida Medical Association.

"Dr. Hall's service to this Association is broad-based and has extended over more than 13 years. His position of recent ascendency with Republicanism in Manatee County is known to us all; no minor point is his association and close liaison with our present Governor, The Honorable Claude Kirk. It is with pleasure that we present the name of Dr. Irving Hall for Vice President."

Dr. Norman F. Coulter, Orange, and Dr. Henry L. Harrell, Marion, seconded the nomination of Dr. J. Basil Hall.

Dr. James A. Winslow, Hillsborough, and Dr. Millard P. Quillian, Manatee, seconded the nomination of Dr. Irving E. Hall Jr.

Motion was carried that nominations be closed.

The Speaker appointed Drs. William H. Van Nortwick, Chairman, Louis P. Brady and William H. Proctor as tellers.

Dr. Irving E. Hall Jr. was elected Vice President.

Nominations were requested for Speaker of the House.

Dr. Henry L. Harrell, Marion: "I believe everyone agrees we have had one of the best run meetings we have had in several years. Several people have been responsible for this, Dr. George Palmer, Dr. Floyd Hurt, Mr. Harold Parham, but I am not going to nominate any one of them. I would like to place in nomination for Speaker of the House, our present Speaker, Dr. Franklin J. Evans. He has proved that he is a real, built-in speaker. He is better qualified than anyone in the Association, and I don't believe we will have an opportunity for some time to have another member who is both a doctor and a lawyer, and I believe we should hold on to him a little longer."

Nomination was seconded by Dr. Ralph Herz, Monroe and Dr. M. Eugene Flipse, Dade.

Dr. Leo M. Wachtel, Duval: "Mr. Speaker, Members of the House of Delegates:

"I would not detract from the ability of our Speaker, Dr. Evans, who has served us well for three long years. I would place in nomination the name of a man who has served and trained under him and I think he has demonstrated today how well he has learned to serve on the podium. I refer to our friend, Jim Cook, a native of Marianna, a graduate of Emory Medical School; incidentally, he now has a son there in medical school. I call to your attention the fact that in 1960 he was chosen by the American Medical Association as 'Doctor of the Year.' I call further to your attention, and you may make of it what you will, this was the last time they chose one. He has served on two occasions as president of his medical society, he is very active in civic affairs and has held many positions on committees and reference committees of this great association.

"For three years Dr. Evans has served us well and for three years Dr. Cook has served us well as Vice Speaker, and I place in nomination for Speaker of the House the name of Dr. James T. Cook."

The nomination of Dr. Cook was seconded by Dr. Thomas M. Quehl, Pinellas, Dr. William F. Brunner, Jackson-Calhoun, Dr. Myrl Spivey, Palm Beach, Dr. James A. Winslow, Hillsborough, Dr. Jesse W. Castleberry, Orange, and Dr. William M. C. Wilhoit, Escambia.

Motion was carried that nominations be closed, and the same tellers were asked to serve for this election.

Dr. James T. Cook was elected Speaker of the House.

The Speaker asked for nomination for Vice Speaker.

Dr. Donald F. Marion, Dade: "I apologize for appearing before you twice today, but I am grateful for the opportunity. It is not often you get to nominate two fine men on the same day. I think every one agrees that the most important job at these meetings is that of our speakers. Since Joe Stewart started the illustrious parade, we have had none but good ones. This doesn't just happen by accident. I am quite sure most of us, while we might aspire to such a job, are simply incapable of doing it. It requires special talent. The man I am suggesting to you for student or Vice Speaker is a man who, I think, has these talents

in great abundance. He is a native Floridian, he was born in St. Petersburg, went to high school there, graduated from St. Petersburg College in 1939 and got his M.D. from Duke in 1943. He served his internship and residency, and was fellow in Cardiology at Duke Hospital, commissioned in the Navy in 1941, active duty in the Navy from 1953 to 1954; he is an internist, which is obvious, and a fine one; he is a Diplomate of the American Board of Internal Medicine, a Fellow of the American College of Physicians, Cardiology, Chest Physicians—I could go on but time will not permit listing all the things he belongs to. Take my word for it—they are all the right things and he is an active, contributing member of all of them. Here in Florida he has been a member of the board of directors of the Florida Heart Association from 1948-1961, board of directors of the Sun Coast Heart Association at present, secretary-treasurer of the Florida Society of Internal Medicine from its founding in July 1956 and it might almost be said that he was the founder of the Florida Society of Internal Medicine, a member of the board of trustees of the American Society of Internal Medicine, 1959-1961, and from 1962-1963 he honored Florida by being president of the American Society of Internal Medicine, and in that year really raised the standards and status of Internal Medicine single-handedly a tremendous amount. He has been a member of the State Tuberculosis Board, assistant editor of our Journal (Thad can tell you that he depends on this fellow a lot in getting out our fine Journal), he has been a member of the Council on Specialty Medicine, and a member of the Fee Schedule Committee. In other words, you can find him wherever there is a lot of work to do and you will find that the work is well done. He manages meetings beautifully, I think he will be an expert student and will eventually succeed to the top spot, and it is a great privilege for me to present to you Dr. Charles Donegan of St. Petersburg in nomination for Vice Speaker."

Nomination was seconded by Dr. Edward J. Haskell Jr., Leon, Dr. Collin F. Baker Jr, Hillsborough, Dr. Truett H. Frazier, Orange, Dr. William W. Thompson, Okaloosa, and Dr. William M. C. Wilhoit, Escambia, who also moved that nominations be closed and the secretary be instructed to cast a unanimous ballot for Dr. Donegan.

Motion was carried, and the Speaker announced that Dr. Donegan was elected Vice Speaker of the House.

The Speaker asked for nominations for the office of Secretary-Treasurer.

Dr. William A. Van Nortwick, Duval: "It gives me great pleasure on behalf of the Duval delegation to place in nomination the name of one of our members, Dr. Floyd K. Hurt. He has filled this position for the last four years most capably."

There were no other nominations and Dr. Holland moved that nominations be closed and the Secretary cast a unanimous ballot for Dr. Hurt. Motion was carried and the Speaker announced that Dr. Hurt had been elected.

Dr. Hurt: "Mr. Speaker, Mr. President, Members of the House: Thank you very much for your vote of confidence, and particularly I appreciate the support of my own delegation. I will continue to do the best I can and with the help of Harold Parham and his staff, I think we will get along."

The Speaker called for election of two delegates and two alternates to the House of Delegates, American Medical Association, for two year terms beginning January 1, 1968 and expiring December 31, 1969.

Dr. Miles W. Thomley, Orange: "I would like to place in nomination the name of a man who has served admirably in various capacities in this organization for the past 15 years. He is a Past President, and expert in medical economic affairs, was an alternate delegate for two years and a delegate for four years, and is now getting his teeth into the national problems. I, therefore, nominate Dr. Robert E. Zellner as AMA Delegate."

Dr. John D. Milton, Dade, seconded the nomination of Dr. Zellner.

Dr. J. Maxey Dell Jr., Alachua, seconded the nomination of Dr. Zellner and moved that the nominations be closed. Motion was carried and the Speaker announced that Dr. Zellner had been elected.

Dr. Walter Sackett nominated Dr. Ralph Jack for Alternate Delegate, and as there were no other nominations, the Speaker declared Dr. Jack elected.

Dr. Anthony C. Galluccio, Broward, nominated Dr. Burns A. Dobbins Jr., as Delegate to the American Medical Association, and as there were no other nominations, the Speaker announced that Dr. Dobbins was elected.

Dr. Louis C. Murray, Orange, nominated Dr. Walter E. Murphree, of Gainesville as Alternate Delegate. As there were no other nominations, the Speaker declared Dr. Murphree elected.

The Speaker called attention to the nominations of the Board of Governors for membership on the Committee on Membership and Discipline and called for nominations from the floor.

Dr. Samuel M. Day withdrew his name from nomination and proposed that of Dr. Hugh Carithers, Duval.

As there were no further nominations from the floor, the Speaker declared the following were elected:

District 1
William C. Roberts, M.D.,
Panama City 1971

District 3
Hugh A. Carithers, M.D.,
Jacksonville 1971

District 5
Frank C. Bone, M.D.,
Orlando 1971

District 7
Gordon H. McSwain, M.D.,
Arcadia 1971

District 9
Myrl Spivey, M.D.,
West Palm Beach 1971

District 10
Miles J. Bielek, M.D.,
Fort Lauderdale 1971

Russell B. Carson, M.D.,
Fort Lauderdale 1969

The Speaker asked for any unfinished business.

Dr. Charles F. Tate Jr., Dade, asked permission to present an emergency resolution requesting the House of Delegates go on record as favoring an increase in cigarette taxes.

The Speaker explained that this could not be considered, as an emergency resolution would require unanimous consent of the House, and there were objections from the floor.

Dr. Sackett presented a resolution of appreciation, which was accepted by the House without reading:

Whereas, legislative matters pertaining in some way to medicine frequently come up before the legislature and this entails a ready and willing source of advice, and

Whereas, the legislators and their staffs are afforded good medical care through the institution of the medical dispensary, and

Whereas, the Leon County Medical Society and, in particular, Dr. George Palmer and Dr. Ed Haskell have been most constant in these regards, and

Whereas, our legislative advisers, Mr. Jack Peeples and Mr. Al James have rendered valuable services; now, therefore, be it

RESOLVED, That this Florida Medical Association House of Delegates forward to the Leon County Medical Society and the named individuals an expression of deep and lasting gratitude for willingly accepting what is on the whole a thankless task well done.

The Speaker announced that Dr. Henry Bryant of Miami won the Duval County Medical Society golf trophy with a score of 74.

The Exhibit Visitation Awards: first prize of $150 to Dr. Lawrence C. Manni; second prize of $100 to Dr. Barry E. Seinfeld, and third prize of $50 to Dr. Samuel E. Kaplan, were announced by the Speaker.

The Speaker announced the ceremony of installing the new President.

Dr. Palmer: "Dean Steward, I share the pride of your Orange County Medical Society in presenting to you one of the symbols of the office of President of the Association, this gavel, which I know you will wield well and be a wonderful 'steward' for this Association during the coming year. Also, your President's plaque to hang on the wall in your office along with all of those predecessors of whom we are so proud."



Dr. W. Dean Steward of Orlando, incoming President, is congratulated by outgoing President Dr. George S. Palmer of Tallahassee.



Dr. George S. Palmer of Tallahassee is presented the Past President's pin by Dr. W. Dean Steward of Orlando, President.

Dr. Steward: "Thank you, George. I am quite humble. I recognize the fact that I am following many distinguished men who have left big and deep marks in the sands of Florida medicine.

"With your help I will do the best that I can to continue to do a good job for Florida medicine and I appreciate beyond words the trust that has been put in me.

"At this time I want to present to this distinguished member of a distinguished Florida family, a close personal friend, and a man I served with on the Blue Shield Board for many years, got to know well, and it has been a privilege and pleasure to serve under him, the Past President's pin—your distinguished President, George Palmer."

Dr. Steward asked Dr. Holland and Dr. Stuart Smith to escort Mrs. Palmer to the rostrum.

Dr. Steward: "Marie, it gives me considerable pleasure to present this fine picture of a distinguished gentleman. It has been suggested you should have received it last year since you didn't have George around to look at. I think this should be considered in the future. I do want to give it to you with the good wishes of the Florida Medical Association."

Dr. Steward announced the members of the Board of Governors to meet immediately after adjournment in the Pan American Room: President-Elect, Dr. Jack Cleveland; Past President, Dr. George S. Palmer; Past President, Dr. H. Phillip Hampton; Speaker of the House, Dr. James T. Cook; Vice President, Dr. Irving E. Hall Jr.; Secretary-Treasurer, Dr. Floyd K. Hurt; AMA Delegate Representative, Dr. Burns A. Dobbins Jr.; State Board of Health representative, Dr. Eugene G. Peek Jr.; Dr. William M. C. Wilhoit, Dr. William J. Dean, Dr. Charles R. Sias, Dr. John J. Cheleden and Mr. W. Harold Parham.

Past President Walter C. Jones gave the benediction: "May the deliberations and actions of this body accrue to the betterment of health in this great state and to the advancement of Thy Kingdom."

The Speaker declared the meeting adjourned at 1:50 p.m.



President's Page

The Democratic Approach

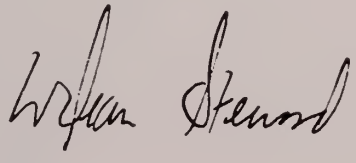
A misconception held by many laymen, and unfortunately by a few physicians, is that the American Medical Association dictates to the members in a manner similar to that of most labor organizations. In fact, the exact reverse is true, and all policies of the American Medical Association are initially formulated at the grass roots by men in active practice who are concerned enough to take part in the organizational side of medicine. This fact was again re-emphasized at the Ninety-Third Annual Meeting of the Florida Medical Association.

Elected delegates from the 43 county medical societies, along with delegates from the Council of Specialty Medicine, met for two days as the House of Delegates at the Americana Hotel in Bal Harbour. As in many other democratic organizations, much of the actual work was carried out in the reference committees where all society business, including resolutions from the component societies, special reports and other items, was presented and discussed. Active members of the Association, and not just delegates alone, were given an opportunity to discuss any subject on the agenda and to express themselves freely. When argumentative questions were considered, the reference committees made decisions based on the wishes of the majority of those present. Reference committee reports were presented to the House of Delegates on the final day of the meeting, and further discussions on some questions ensued. Finally, all questions of policy, all resolutions, recommendations and reports were acted on by the full House. In such a way does the Florida Medical Association carry out its business.

The same is true of the American Medical Association. The state delegates from Florida meet with the representative delegates from the other states in two meetings annually. The same democratic procedure is carried out, with reference committees conducting hearings where *any* member of the American Medical Association may appear and express his views. At these same committee meetings, the delegates from Florida along with those from other states express the wishes of their component societies regarding matters of policy affecting the physician and medical practice in America.

Because of the rapid pace of our civilization and the ever changing problems presented, interim decisions are made by the Board of Trustees of the AMA and by the Board of Governors of the FMA. Actions taken by these boards are subject to review and acceptance, to revisions or to reversal by the respective houses of delegates at their next meeting. Because of this delay, there is sometimes a lag or time gap between the expressed wishes of the members and the official position taken. This is at times unfortunate, but there is no other way in which the business of an organization of this magnitude can be satisfactorily carried out. In the long run, freedoms are protected and the wishes of the majority set the policies.

The preceding statements are "old hat" to all of the men who have been active in the Florida Medical Association over the years. Many new physicians are entering practice, however, and this is written with the express desire to inform them and to urge them to take an interest in the affairs of organized medicine at the county level, the state level and nationally.



This "case history" runs to some 10,000 pages

This is a typical "case history" of one new drug—or, rather, a proposed new drug—assembled for submission to the U.S. Federal Food and Drug Administration. These volumes are the result of several years' work by thousands of professional and skilled personnel in just one pharmaceutical company's research laboratories, and by hundreds of physicians in medical schools, hospitals, and private practice. They cover every aspect of experience with this proposed new agent from chemical laboratory to clinic, from mouse to man. Each volume could conceivably represent hundreds of thousands of dollars of financial investment, countless hours of human effort. This veritable mountain of data stands behind every new agent offered to you by pharmaceutical manufacturers—a reassuring testimonial to the efficacy, safety and purity of the drugs you will prescribe today to lower the cost of disease to your patients.

Pharmaceutical Manufacturers Association
Pharmaceutical Advertising Council

1155 Fifteenth St., N. W., Washington, D.C. 20005



This message is brought to you as a courtesy of this publication on behalf of the producers of prescription drugs.

In peptic ulcer... antacid therapy with a new benefit



CONTAINS A BALANCED COMBINATION OF THE MOST WIDELY USED ANTACIDS— FOR RAPID NEUTRALIZATION. PLUS SIMETHICONE— TO CONTROL THE FACTOR WHICH ANTACIDS ALONE CANNOT INFLUENCE.

Mylanta®

- In Mylanta, aluminum and magnesium hydroxides are balanced to minimize the chance of constipation or laxation and still achieve rapid acid neutralization and pain relief.
- The positive action of simethicone helps relieve the painful gas symptoms which often accompany the peptic ulcer syndrome.
- The nonfatiguing flavor and smooth, nongritty consistency of tablets and liquid encourage continued patient cooperation during long-term therapy.

Composition: Each Mylanta chewable tablet or teaspoonful (5 ml.) of liquid contains: magnesium hydroxide, 200 mg.; aluminum hydroxide, dried gel, 200 mg.; simethicone, 20 mg. **Dosage:** one or two tablets, well chewed or allowed to dissolve in the mouth, or one or two teaspoonfuls of liquid to be taken between meals and at bedtime.

The Stuart Company, Pasadena, California
Division of Atlas Chemical Industries, Inc.

Stuart



HIGHLAND HOSPITAL

ASHEVILLE, NORTH CAROLINA

Founded 1904

A DIVISION OF THE DEPARTMENT OF PSYCHIATRY
OF DUKE UNIVERSITY

Accredited by the Joint Commission on Accreditation and Certified for Medicare

Complete facilities for evaluation of and intensive treatment of psychiatric patients, including individual psychotherapy, group therapy, psychodrama, electro-convulsive therapy, Indoklon convulsive therapy, drugs, social service work with families, family therapy, and an extensive and well organized activities program, including occupational therapy, art therapy, athletic activities and games, recreational activities and outings. The treatment program of each patient is carefully supervised in order that the therapeutic needs of each patient may be realized.

Complete modern facilities with 85 acres of landscaped and wooded grounds in the City of Asheville.

Brochures and information on financial arrangements available
Contact: Mrs. Elizabeth Harkins, ACSW, Coordinator of Admissions

or

Charles W. Neville, Jr., M.D.
Assistant Professor of Psychiatry and Medical Director
Area Code 704 - 253-2761

A COMPLETE BUSINESS SERVICE

FOR THE MEDICAL
AND DENTAL
PROFESSIONS

Professional Management

PM FLORIDA

233 Fourth Ave, N.E.
St. Petersburg, Florida
Phone 898-5074

1855 Hillview Street
Sarasota, Florida
Sarasota Phone 958-4493
4771 Bilmark
Ft. Myers, Florida
Ft. Myers Phone 936-3162

PROFESSIONAL MANAGEMENT FOR PHYSICIANS AND DENTISTS
since 1932 PM

417 Executive Building
1175 N.E. 125th St.
Miami, Florida 33125
Dade Phone 751-2101
Broward Phone 523-0286

Affiliates of Black & Skaggs Associates
Battle Creek, Michigan

YOUR Patronage Has Made Our Growth Possible

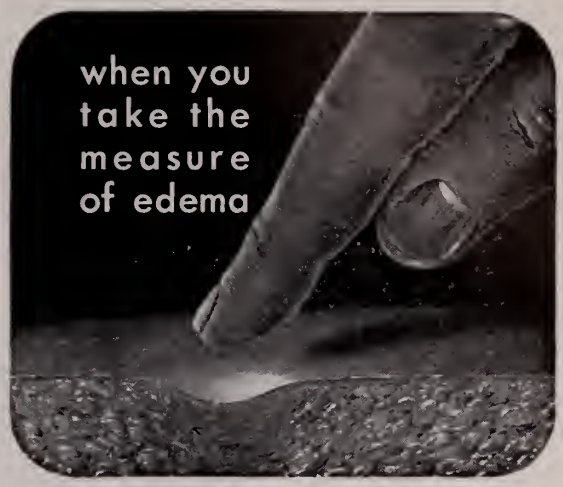
Medical Supply Company of Jacksonville



Home Office

JACKSONVILLE
4539 Beach Blvd.
Telephone FL 9-2191

ORLANDO
1511 Sligh Blvd.
Telephone GA 5-3537



. . . introduce your patient to

AQUATAG®
(BENZTHIAZIDE)

AQUATAG (Benzthiazide) is a potent, orally active, nonmercurial, diuretic agent. It is effective orally in producing diuresis in edema states, where it is therapeutically comparable to mercurials given parenterally. AQUATAG (Benzthiazide) is mildly antihypertensive in its own right and enhances the action of other antihypertensive drugs when used in combination.

DIURETIC ACTION: Clinically, the oral administration of AQUATAG (benzthiazide) results in diuretic activity within two hours with maximal natriuretic, chloruretic, and diuretic effects occurring during the fourth, fifth and sixth hours. Maintenance of response continues for approximately 12 to 18 hours. Acidosis is an unlikely complication since therapeutic doses of AQUATAG (benzthiazide) do not appreciably increase bicarbonate excretion. Edematous patients receiving 50 mg. of AQUATAG (benzthiazide) daily for five days developed a maximal increase in the rate of sodium excretion on the first day, and maintained this high rate until depletion of excessive body stores of sodium.

In congestive heart-failure patients, AQUATAG (benzthiazide) produced the same weight loss, during a 48-hour treatment period as did a maximally effective dose of hydrochlorothiazide.

DOSAGE: Diuresis, initially 50 to 200 mg.; maintenance 25 to 150 mg., daily. Hypertension 50 to 100 mg. initially, adjusted to 50 mg. t.i.d. or downward to minimal effective dosage level.

WARNINGS: Use with caution in the presence of renal disease as azotemia may be precipitated or increased. In patients with advanced hepatic disease, electrolyte imbalance may result in hepatic coma. Dosage of coadministered antihypertensive agents should be reduced by at least 50%. In cases of suspected electrolyte imbalance, serum electrolyte determinations should be performed and imbalance, if any, corrected. Stenosis or ulcer of small intestine have been reported with coated potassium formulas, and surgery has been required and deaths have occurred. Based on surveys of both United States and foreign physicians, incidence of these lesions is low and a causal relationship in man has not been definitely established. Until further experience has been obtained, the use of the drug in pregnant patients should be weighed against possible hazards to the fetus.

CONTRAINDICATIONS: AQUATAG (benzthiazide) is contraindicated in progressive renal disease or dysfunction including increasing oliguria and azotemia. Continued administration of this drug is contraindicated in patients who show no response to its diuretic or antihypertensive properties. Severe hepatic disease is a relative contraindication. (See "Warnings" above.)

PRECAUTIONS AND SIDE EFFECTS: Electrolyte imbalance with hypokalemia (digitalis toxicity may be precipitated), hypochloremic alkalosis and hyponatremia may occur.

Patients with cirrhosis should be observed for impending hepatic coma and hypokalemia. Other reactions may include blood dyscrasias, hyperuricemia and gout, nausea, jaundice, anorexia, vomiting, diarrhea, dizziness, paresthesia, photosensitivity and headache. Hepatic fetor, tremor, confusion and drowsiness are signs of impending pre coma and coma in patients with cirrhosis. Insulin requirements may be altered in diabetes. AQUATAG (benzthiazide) should be used with caution post-operatively as hypokalemia is not uncommon. Potassium supplementation may be advisable pre- and post-operatively. There have been occasional reports of thrombocytopenia, leukopenia, agranulocytosis, aplastic anemia and precipitation of acute pancreatitis or jaundice.

Before prescribing or administering, read the package insert or file card available on request.

Available as 25 or 50 mg. scored tablets.

Request clinical samples and literature on your letterhead.

S.J. TUTAG
& COMPANY
Detroit, Michigan 48234



Government News

HEW Task Force Studies Medicare Drug Question

The Department of Health, Education, and Welfare is making a broad study of prescription drugs which will be the basis of a recommendation on whether their costs should be covered by medicare when they are used outside a hospital.

HEW Secretary John W. Gardner appointed a task force of HEW officials to evaluate the study and make the recommendation.

"Prescription drugs are an essential element of modern medical care," Gardner said. "In the last 25 years we have witnessed greater advances in the use of drugs than in the whole previous history of medicine. Today drugs and biologicals make possible the prevention and successful treatment of illnesses that were serious and frequently fatal.

"Yet for many older Americans the cost of needed drugs prescribed by a physician is a heavy burden, representing 15% to 20% of their medical care costs. Many older Americans find themselves with limited financial resources at the very time that age brings an increasing incidence of chronic disease and greater needs for medical care, including prescription drugs."

President Johnson directed last January that Gardner "undertake immediately a comprehensive study of the problems of including the cost of prescription drugs under medicare." Studies on some aspects of the question were started then and are near completion. Other specific studies are in various stages of progress.

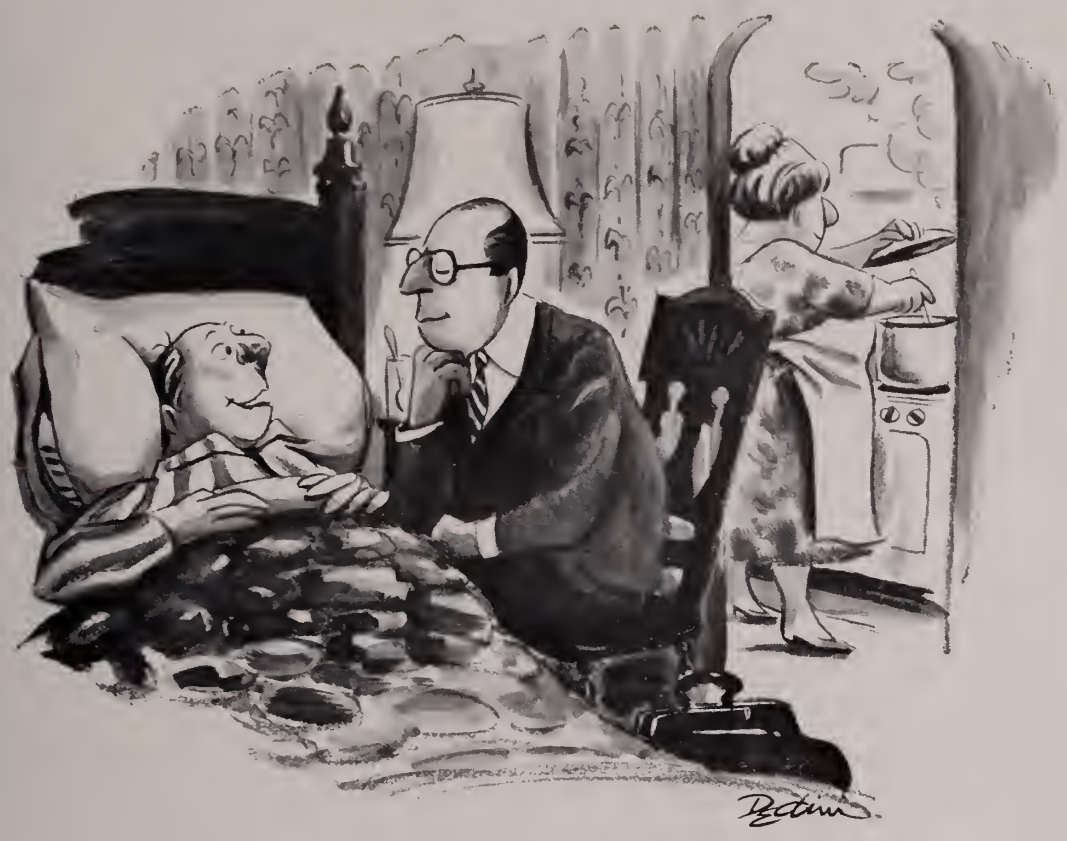
But Congress may decide the issue before the full study is completed. The Senate Finance Committee will hold hearings this summer on such a medicare extension.

Dr. Philip R. Lee, Assistant HEW Secretary and Chairman of the task force, said that even if the study is incomplete, HEW will take a stand anyway when the Senate Finance Committee takes up the legislation.

One bill would finance medicare coverage of drugs by increasing from $3 to $4 the cost of monthly premiums for the voluntary doctor bills insurance program (Plan B) for persons 65 and over. Sponsored by Sen. Joseph M. Montoya (D., N.M.) the bill would provide that generic drugs rather than trade name products be used whenever possible.

Another bill is sponsored by Chairman Russell B. Long, (D., La.), the Senate's leading critic of the drug industry. It would spur generic purchasing for all federally-connected welfare programs.

"The task force will examine a number of factors which are closely involved with the use of prescription drugs and with present and proposed methods of purchasing them," Lee said. "Many of these factors concern not only drug costs—and who pays them—but also the quality of medicare care."



"When I couldn't even smell corned beef and cabbage, I decided it was time for you, Doc."

Maybe he doesn't know when he's well off. But you might want to prescribe long-acting Novahistine LP anyway.

Two tablets in the morning and two in the evening will usually provide day and night relief by helping to clear congested air passages for normal, free breathing. Novahistine LP is formulated to provide continuous therapeutic effect for 8 to 12 hours. The decongestant ingredients help restore normal mucus secretion and ciliary activity—physiologic defenses against infection of the respiratory tract.

Use cautiously in individuals with severe hypertension, diabetes mellitus, hyperthyroidism or urinary retention. Caution ambulatory patients that drowsiness may result. Each Novahistine LP tablet contains: phenylephrine hydrochloride, 25 mg., and chlorpheniramine maleate, 4 mg.

NOVAHISTINE® LP

DOW **PITMAN-MOORE** Division of The Dow Chemical Company, Indianapolis



"All Interns are Alike"

It stands to reason. They all go through the same training; they all have to pass the same tests; they all have to measure up to the same standards; they all are underpaid, too. Therefore, all interns are alike.

That's utter nonsense, of course. But it's no more nonsensical than what some people say about aspirin. Namely: since all aspirin is at least supposed to come up to certain required standards, then all aspirin tablets must be alike.

Bayer's standards are far more demanding. In fact, there are at least *nine specific differences* involving purity, potency and speed of tablet disintegration. These Bayer® standards result in significant product benefits including gentleness to the stomach, and product stability that enables Bayer tablets to *stay* strong and gentle until they are taken.

So next time you hear someone say that all aspirin tablets are alike, you can say, with confidence, that it just isn't so.

You might also say that all interns aren't alike, either.





"Take a laxative" is a harsh sentence

Although there are more than 60 ethical laxatives available for the constipated patient, many, unfortunately, do not really produce an effect much like a normal bowel movement. Instead they whip the bowel, torment it and leave it irritated, inflamed and exhausted.
On the other hand, Dulcolax provides a nearly normal movement. Through its unique contact action, it induces the kind of natural contraction waves of the colon necessary for gentle, complete, comfortable bowel movements.
For your next constipated patient, try Dulcolax–the laxative with the gentle touch.

Dulcolax, brand of bisacodyl tablets (5 mg.)

Under license from
Boehringer Ingelheim
G.m.b.H.

Geigy Pharmaceuticals
Division of
Geigy Chemical Corporation
Ardsley, New York

Dulcolax®
a gentle persuasion

Geigy

The AMBAR SCRAPBOOK of Obesity Oddities

FACT & LEGEND

CHARLES DICKENS'

"FAT BOY JOE"

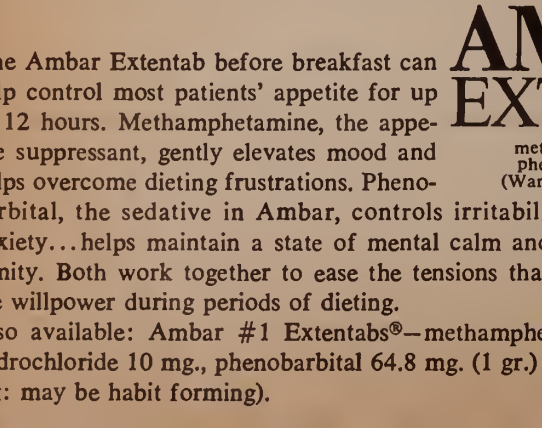
in Pickwick Papers

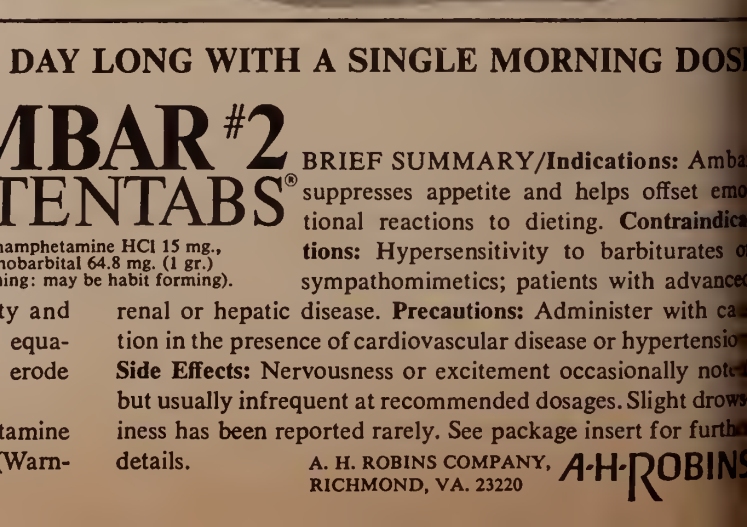
IS THE FIRST RECORDED CASE OF OBESITY WITH NARCOLEPSY

DR. C. SIDNEY BURWELL COINED THE TERM "PICKWICKIAN SYNDROME" IN 1955!



Obese Epitaph in English graveyard





CONTROL FOOD AND MOOD ALL DAY LONG WITH A SINGLE MORNING DOSE

AMBAR #2 EXTENTABS®

methamphetamine HCl 15 mg., phenobarbital 64.8 mg. (1 gr.) (Warning: may be habit forming).

One Ambar Extentab before breakfast can help control most patients' appetite for up to 12 hours. Methamphetamine, the appetite suppressant, gently elevates mood and helps overcome dieting frustrations. Phenobarbital, the sedative in Ambar, controls irritability and anxiety... helps maintain a state of mental calm and equanimity. Both work together to ease the tensions that erode the willpower during periods of dieting.

Also available: Ambar #1 Extentabs®—methamphetamine hydrochloride 10 mg., phenobarbital 64.8 mg. (1 gr.) (Warning: may be habit forming).

BRIEF SUMMARY/**Indications:** Amba suppresses appetite and helps offset emo tional reactions to dieting. **Contraindica tions:** Hypersensitivity to barbiturates o sympathomimetics; patients with advance renal or hepatic disease. **Precautions:** Administer with ca tion in the presence of cardiovascular disease or hypertensio **Side Effects:** Nervousness or excitement occasionally note but usually infrequent at recommended dosages. Slight drows iness has been reported rarely. See package insert for furth details.

A. H. ROBINS COMPANY, RICHMOND, VA. 23220 A·H·ROBINS



New view of an oral contraceptive at work

Although suppression of ovulation remains the primary mode of action of oral contraceptives, newer knowledge indicates that products like Norinyl-1—a combination of both low-dosage progestogen and estrogen for the full treatment cycle—may provide multiple action that helps explain their unexcelled record of contraceptive effectiveness. This report explores the possible secondary protective mechanisms offered by combined hormonal administration.

Accumulating evidence has indicated that sparse, highly viscous cervical mucus has a possible adverse effect on the motility and survival of spermatozoa.

The estrogen-opposing progestational ingredient of Norinyl-1 (norethindrone 1 mg. with mestranol 0.05 mg.) changes the usual mid-cycle picture of a thin, watery cervical mucus. The result—a built-in barrier that appears to inhibit sperm from reaching the ovum should one be released. The inset in the adjoining photograph shows immobile spermatozoa as they appear in cervical mucus taken from a patient treated with Norinyl-1.

See last page for contraindications, precautions, side effects and dosage.

How the estrogen-opposing action of Norinyl-1 creates cervical mucus that may be hostile to sperm penetration

Normally, estrogen activity during the fertile midcycle stimulates the production of a profuse and watery cervical mucus that permits maximum sperm motility and promotes penetration.

But what happens when Norinyl-1 is administered? Its potent progestogen, norethindrone, opposes estrogen stimulation of cervical mucus. Consequently, the amount of mucus decreases and its viscosity increases. This results in a sparse but thick mucus barrier that appears to diminish the vitality of the sperm and to impair its powers of penetration.

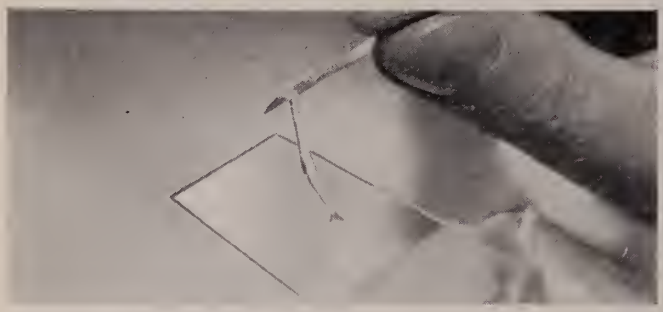
The role of viscous cervical mucus as a secondary action of Norinyl-1

In a report on 89 patients taking this medication,* cervical mucus obtained from cycle day 5 to cycle day 29 appeared scant and thick and exhibited little or no Spinnbarkeit.

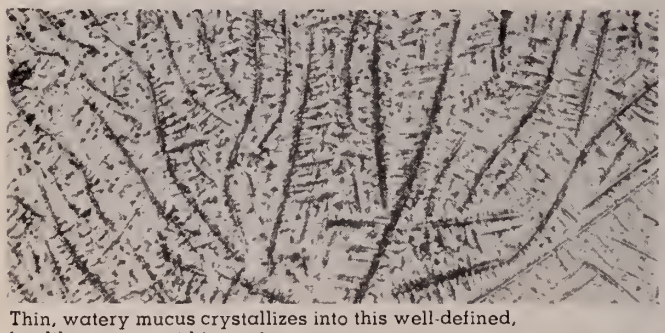
In the opinion of this investigator, the effect on cervical mucus may be sufficient to prevent conception.

*Cohen, M. R.: Symposium: Mechanisms of Action of Low Dosage Oral Contraceptive, Yale University Medical Center, New Haven, Conn., April 6, 19

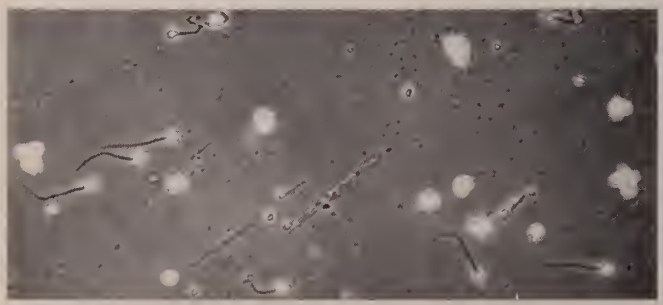
Normal cervical mucus at midcycle in untreated patient is known to permit sperm motility... promote sperm penetration.



Cervical mucus is thin and watery with a stretchability (Spinnbarkeit) of 15 to 20 cm.



Thin, watery mucus crystallizes into this well-defined, fernlike pattern within a minute.

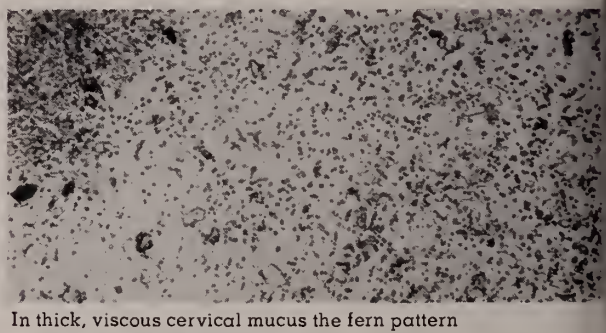


Spermatozoa appear healthy, are active and freemoving.

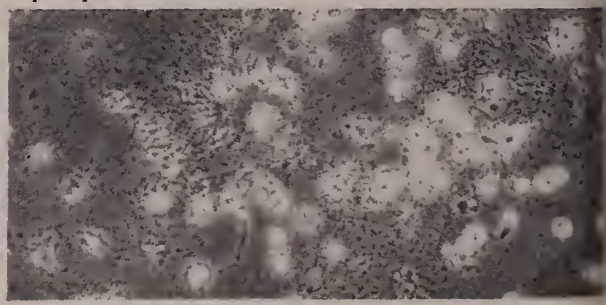
Viscous cervical mucus at midcycle produced by Norinyl-1 appears to impair sperm vitality... inhibit penetration.



Cervical mucus is scanty, thick and viscous. Spinnbarkeit is 1 cm. or less.



In thick, viscous cervical mucus the fern pattern is poorly defined or absent.



Immobile spermatozoa as they appear in cervical mucus taken from a patient treated with Norinyl-1.

ow Norinyl-1 lters normal ndometrial responses— nother possible rotective mechanism

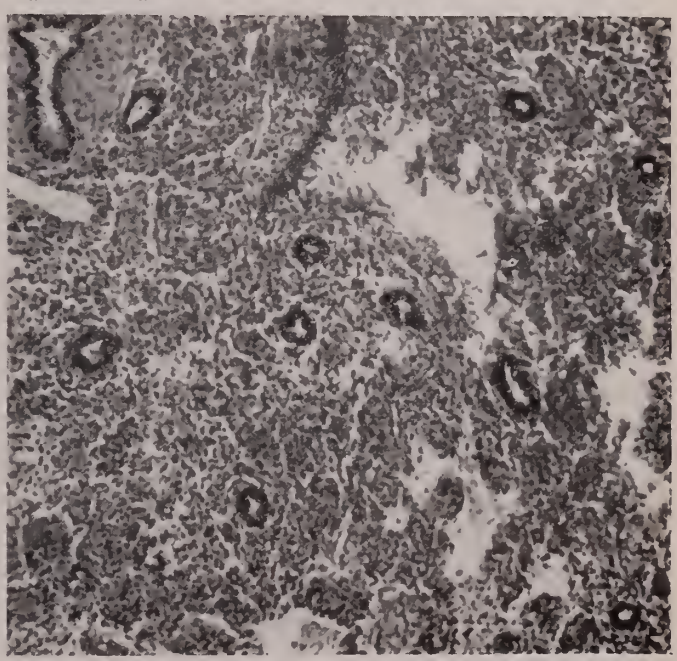
ıs suppose that an ovum is released—as occurs in an sional, rare case—and somehow a sperm succeeds in etrating the cervical mucus barrier. Should this come about, additional action of Norinyl-1 may protect the patient unwanted pregnancy. The theory is that progestogen intake es endometrial tissue unreceptive to implantation.

lometrium of eated patient



nally, the endometrium progresses through liferative phase stimulated by estrogen and a etory phase stimulated by progesterone. ng the secretory phase the endometrium is ptive to the fertilized ovum.

Endometrium produced by Norinyl-1



When Norinyl-1 is administered its progestogen component—norethindrone—accelerates the secretory phase and suppresses glandular and vascular development.

new Norinyl-1® tablets

(norethindrone 1mg. & mestranol 0.05mg.)

ast page for contraindications, precautions, side effects and dosage.

effective fertility control
on half the previous dosage

maintains ratio
of the established
norethindrone/mestranol
combination

lower cost

new Norinyl®

(norethindrone 1mg. c mestranol 0.05mg.) tablets

Reduction of oral contraceptive dosage to lowest effective levels become a well-accepted principle of conservative medical pra In keeping with this view, Norinyl is now available in a new stre in which *both* norethindrone and mestranol are reduced 50 pe Studies show that Norinyl-1 achieves fertility control with only mg. of combined progestogen and estrogen per tablet.

Norethindrone was first reported for use as a progestational age human beings in 1955. Norethindrone 2 mg. with mestranol 0.1 mg an oral contraceptive, is currently in use by over 2,000,000 wo Clinical experience now establishes that Norinyl-1 also amply m the criteria of reliability and safety.*

*Symposium on Low-Dosage Oral Contraception, Palo Alto, Calif., July 15, 1965.

PRESCRIBING INFORMATION

Contraindications: 1. Patients with thrombophlebitis or with a history of thrombophlebitis or pulmonary embolism. 2. Liver dysfunction or disease. 3. Patients with known or suspected carcinoma of the breast or genital organs. 4. Undiagnosed vaginal bleeding.

Warnings: 1. Discontinue medication pending examination if there is sudden partial or complete loss of vision or if there is a sudden onset of proptosis, diplopia, or migraine. If examination reveals papilledema or retinal vascular lesions, medication should be withdrawn. 2. Since the safety of Norinyl-1 in pregnancy has not been demonstrated, it is recommended that for any patient who has missed two consecutive periods, pregnancy should be ruled out before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule, the possibility of pregnancy should be considered at the time of the first missed period. 3. Detectable amounts of the active ingredients in oral contraceptives have been identified in the milk of mothers receiving these drugs. The significance of this dose to the infant has not been determined.

Precautions: 1. The pretreatment physical examination should include special reference to breast and pelvic organs, as well as a Papanicolaou smear. 2. Endocrine and possibly liver function tests may be affected by treatment with Norinyl-1. Therefore, if such tests are abnormal in a patient taking Norinyl-1, it is recommended that they be repeated after the drug has been withdrawn for 2 months. 3. Under the influence of estrogen-progestogen preparations, preexisting uterine fibroids may increase in size. 4. Because these agents may cause some degree of fluid retention, conditions that may be influenced by this factor, such as epilepsy, migraine, asthma, cardiac, or renal dysfunction, require careful observation. 5. Although a cause and effect relationship has not been established, Norinyl-1 should be used with caution in patients with a history of cerebrovascular accident. 6. In relation to breakthrough bleeding, as in all cases of irregular bleeding per vaginam, nonfunctional causes should be borne in mind. In cases of undiagnosed vaginal bleeding, adequate diagnostic measures are indicated. 7. Patients with a history of psychic depression should be carefully observed and the drug discontinued if the depression recurs to a serious degree. 8. Any possible influence of prolonged Norinyl-1 therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study. 9. A decrease in glucose tolerance has been observed in a small percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be carefully observed while receiving Norinyl-1 therapy. 10. Because of the occasional occurrence of thrombophlebitis and pulmonary embolism in patients taking oral contraceptives, the physician should be alert to the earliest manifestations of the disease. A cause and effect relationship has not been demonstrated. 11. Because of the effects of estrogens on epiphyseal closure, Norinyl-1 should be used judiciously in young patients in whom bone growth is not complete. 12. The age of the patient constitutes no absolute limiting factor, although treatment with Norinyl-1 may mask the onset of the climacteric. 13. The pathologist should be advised of Norinyl-1 therapy when relevant specimens are submitted.

Side Effects: The following adverse reactions have been observed with varying incidence in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms, breakthrough bleeding, spotting, change in menstrual flow, amenorrhea, edema, chloasma, breast changes (tenderness, enlargement and secretion), loss of scalp hair, change in weight (increase or decrease), changes in cervical erosion and cervical secretions, suppression of lactation when given immediately postpartum, cholestatic jaundice, erythema multiforme, erythema nodosum, hemorrhagic eruption, migraine, rash (allergic), itching, rise in blood pressure in susceptible individuals, mental depression.

The following occurrences have been observed in users of oral contraceptives. A cause and effect relationship has not been established: thrombophlebitis, pulmonary embolism, neuroocular lesions.

The following laboratory results may be altered by the use of oral contraceptiv creased bromsulphalein retention and hepatic function tests, coagulation te crease in prothrombin, factors VII, VIII, I X), thyroid function (increase in PBI an nol extractable protein-bound iodine a crease in T^3 values), metapyrone test, pre diol determination.

Other side effects reported to have oc in association with use of this drug ar ness, hirsutism, pains in legs, back, che abdomen, dysuria, drowsiness, vagin charge, libido increased and decreased tions, hypermenorrhea, hypomeno increased appetite, G.U. infections, vc veins, abdominal fullness, acne, hea nervousness, allergies, blurred vision, p eyes, and itching in eyes. For complete d *data, see package insert.*

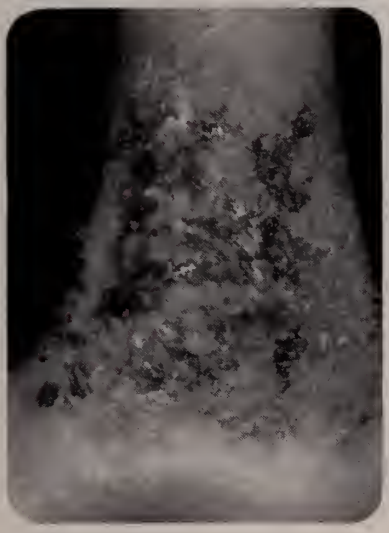
Dosage and Administration: 1. One tab Norinyl-1 is administered orally for 20 beginning on day 5 of the menstrual (Count day 1 of the cycle as the first d menstrual bleeding.) Repeat this dosage ule for each cycle. 2. If no menstrual occurs after a cycle of treatment (20 tabl which patient adhered to the schedule, t tient must be instructed to resume takir Norinyl-1 tablets 7 days after the previ day course was completed. For example, last pill of a previous cycle had been tal a Sunday, then a new cycle of treatment s begin on the following Sunday. 3. In th partum woman, it is recommended th first cycle of treatment should begin on of the first menstrual cycle. However, Nc should not be administered during lactati

Availability: Norinyl-1 (norethindrone with mestranol 0.05 mg.)—Dispensers of 60 and bottles of 250 tablets.

norethindrone — an original steroid from

SYNTEX LABORATORIES INC., PALO ALTO, CALIF.

Eczema of many years... controlled in two weeks



Before treatment



After treatment — with ARISTOCORT Topical Ointment 0.1% for two weeks

ARISTOCORT® Triamcinolone Acetonide Topicals have proved exceptionally effective in the control of various forms of eczema: allergic, atopic, nummular, psoriatic, and mycotic.

In most cases responsive to topical ARISTOCORT, the 0.1% concentration is sufficiently potent. The 0.5% concentration provides enhanced topical activity for patients requiring additional potency for proper relief.

Administration and Dosage: Apply sparingly to the affected area 3 or 4 times daily. Some cases of psoriasis may be more effectively treated if the 0.1% Cream or Ointment is applied under an occlusive dressing.

Contraindications: Tuberculosis of the skin, herpes simplex, chicken pox and vaccinia.

Precautions and Side Effects: Do not use in the eyes or in the ear (if drum is perforated). A few individuals react unfavorably under certain conditions. If side effects are encountered, the drug should be discontinued and appropriate measures taken. Use on infected areas should be attended with caution and observation, bearing in mind the potential spreading of infection and the advisability of discontinuing therapy and/or initiating antibacterial measures. Generalized dermatological conditions may require systemic corticosteroid therapy. Steroid therapy, although responsible for remissions of dermatoses, especially of allergic origin cannot be expected to prevent recurrence. The use over extensive body areas, with or without occlusive nonpermeable dressings, may result in systemic absorption. Appropriate precautions should be taken. When occlusive nonpermeable dressings are used, miliaria, folliculitis and pyodermas will sometimes develop. Localized atrophy and striae have been reported with the use of steroids by the occlusive technique. When occlusive nonpermeable dressings are used, the physician should be aware of the hazards of suffocation and flammability. The safety of use on pregnant patients has not been firmly established. Thus, do not use in large amounts or for long periods of time on pregnant patients.

Available in 5 Gm. and 15 Gm. tubes and ½ lb. jars.

PHOTOGRAPHS COURTESY OF M. M. NIERMAN, M.D.

Aristocort® Topical Ointment 0.1% and Cream 0.1%, 0.5%
Triamcinolone Acetonide
Also available in foam form.

Lederle LEDERLE LABORATORIES, A Division of American Cyanamid Company, Pearl River, New York

406-6

APPALACHIAN HALL

ASHEVILLE Established 1916 NORTH CAROLINA



An Institution for the diagnosis and treatment of Psychiatric and Neurological illnesses, rest, convalescence, drug and alcohol habituation.

Insulin Coma, Electroshock and Psychotherapy are employed. The Institution is equipped with complete laboratory facilities including electroencephalography and X-ray.

Appalachian Hall is located in Asheville, North Carolina, a resort town, which justly claims an all around climate for health and comfort. There are ample facilities for classification of patients, rooms single or en suite.

Wm. Ray Griffin Jr., M.D.
Robert A. Griffin, M.D.

Mark A. Griffin Sr., M.D.
Mark A. Griffin Jr., M.D.

TUCKER HOSPITAL, INC.

212 West Franklin Street

Richmond, Virginia

A private hospital for diagnosis and treatment of psychiatric and neurological disorders. Hospital and out-patient services.

James Asa Shield, M.D.
George S. Fultz, Jr., M.D.
Catherine T. Ray, M.D.

Weir M. Tucker, M.D.
Edward W. Gamble, III, M.D.
Gerald W. Atkinson, M.D.



Ballast Point Manor

5226 Nichols St., P. O. Box 13467 Phone 831-4191
Tampa, Florida

Don Savage, Owner-Manager

Care of mild mental cases, senile disorders and invalids. Alcoholics treated. Aged adjudged cases will be accepted on either permanent or temporary basis.

Thomas B. Slade Fifty Years in Florida J. Beatty Williams

Surgical SUPPLY COMPANY

HAMILTON — RITTER — SKLAR — BURDICK
CLAY-ADAMS — B-D — BARD-PARKER — TYCOS
BAUM — WELCH-ALLYN AND MANY, MANY OTHERS

Ph. 355-8391 P. O. Box 2580 — 1050 W. Adams Street Jacksonville, Fla. 32203



P. L. DODGE MEMORIAL HOSPITAL

M. G. Isaacson, M.D.
Medical Director
1861 N.W. South River Drive
Miami, Florida
Phone 379-1448

A nonprofit-voluntary hospital for the treatment of nervous and mental disorders and the problems of drug addiction and alcoholic habituation. Modern diagnostic and treatment procedures including—Psychotherapy, Insulin, & Electroshock, when indicated. Adequate facilities for recreation and out-door activities. Admissions are made without regard to race, color or national origin.

Information on request
Member NAPPH, American Psychiatric Assn., & American Hospital Assn.

Convention Press

2111 North Liberty St.
Jacksonville, Florida
32206

QUALITY BOOK PRINTING
PUBLICATIONS BROCHURES

Whatever your first requisites may be, we always endeavor to maintain a standard of quality in keeping with our reputation for fine work —and at the same time provide the service desired. Let Convention Press help solve your printing problems by intelligently assisting on all details.

Anderson Surgical Supply Co.

Established 1916

Distributors of Known Brands of Proven Quality

TELEPHONE 229-8504
Morgan at Platt, P. O. Box 1228
TAMPA, FLORIDA 33601

TELEPHONE 896-3107
556 9th St., South
ST. PETERSBURG, FLORIDA

TELEPHONE 376-8253
236 S.W. 4th Ave.
GAINESVILLE, FLORIDA

TELEPHONE CHerry 1-9589
1818 N. Orange Ave.
ORLANDO, FLORIDA

Hill Crest HOSPITAL

(Formerly Hill Crest Sanitarium)

7000 5TH AVENUE SOUTH
Box 2896, Woodlawn Station
Birmingham, Alabama 35212
Phone: 205 - 836-7201

A patient centered independent hospital for intensive treatment of nervous disorders . . .

Hill Crest Hospital was established in 1925 as Hill Crest Sanitarium to provide private psychiatric treatment of nervous or mental disorders. Individual patient care has been the theme during its 42 years of service.

Both male and female patients are accepted and departmentalized care is provided according to sex and the degree of illness.

In addition to the psychiatric staff, consultants are available in all medical specialities.



MEDICAL DIRECTOR:
James A. Becton, M.D., F.A.P.A.

CLINICAL DIRECTORS:
James K. Ward, M.D., F.A.P.A.
Hardin M. Ritchey, M.D., F.A.P.A.

HILL CREST is a member of:
AMERICAN HOSPITAL ASSOCIATION NATIONAL ASSOCIATION OF PRIVATE PSYCHIATRIC HOSPITALS . . . ALABAMA HOSPITAL ASSOCIATION . . . BIRMINGHAM REGIONAL HOSPITAL COUNCIL.
Hill Crest is fully accredited by the Joint Commission on Accreditation of Hospitals.

Hill Crest HOSPITAL
BIRMINGHAM, ALABAMA

Gebauer's Ethyl Chloride stops creeping eruption cold





highly magnified drawing of the Ancylostoma Braziliense

Creeping eruption is ugly, uncomfortable, and persistent. And, in Florida, it is seen with considerable frequency.

Creeping eruption is caused by the larvae of the dog and cat hookworm, *Ancylostoma Braziliense*. The larvae of this parasite burrow between the superficial layers of the skin, causing much discomfort and characteristic angry eruptions.

Happily, Gebauer Ethyl Chloride sprayed on the affected area for 30 seconds to one minute will usually kill the offending larvae. In difficult cases, it may be necessary to spray for a period of up to two minutes. Improvement and cure generally follow a comparatively few applications.

Next time you treat creeping eruption, treat it with Gebauer Ethyl Chloride. Also highly effective as a topical anesthetic for minor surgery, as in removal of splinters, incision of boils and whitlows, and to alleviate needle pain. May be used for relief of pain such as first and second degree burns, bee stings, sprains and muscle spasm.

GEBAUER PRODUCTS AVAILABLE AT

CORAL GABLES: Surgical Equipment Co. JACKSONVILLE: Central Medical & Surgical Supply • Hermax Corporation • Medical Supply Co. of Jacksonville • Surgical Supply Co. MIAMI: Amedic Surgical Co. • Florida Physicians Supply • Medical Supply Co. ORLANDO: Anderson Surgical Supply Co. • Medical Supply Co. ST. PETERSBURG: Anderson Surgical Supply Co. SARASOTA: Anderson Surgical Supply Co. TALLAHASSEE: Southeastern Surgical Supply Co. TAMPA: Anderson Surgical Supply Co. • Medical Supply Co. • Southern Surgical Supply Co. • Surgical Equipment Co. of Florida. WEST PALM BEACH: Medical Associates Corp. • Medical Supply Co.

OR YOUR LOCAL PHARMACY

Gebauer's

GEBAUER CHEMICAL COMPANY

9410 St. Catherine Ave. • Cleveland, Ohio 44104



when he just can't sleep

Tuinal

One-Half Sodium Amobarbital an
One-Half Sodium Secobarbit
supplied in ¾, 1½, and 3-grain Pulvule



uinal helps wakeful patients fall asleep fast, stay sleep all night.

dications: Tuinal is indicated for prompt and moderately long-acting hypnosis. It is not suitable for continuous daytime sedation.

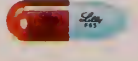
ontraindications: Barbiturates should not be administered to anyone with a history of porphyria, nor should they be given in the presence of uncontrolled pain, because excitement may result.

Warning: May be habit-forming.

recautions: Tuinal should be used cautiously in patients with decreased liver function, since prolongation of effect may occur.

dverse Reactions: Idiosyncrasy, such as excitement, hangover, or pain, may appear. Hypersensitivity reactions occur in some patients, especially in those with asthma, urticaria, or angioneurotic edema.

Overdosage: C.N.S. depression. Symptoms—Depression of respiration and of superficial and deep reflexes, slight constriction of the pupils (in severe poisoning, dilation), decreased urine formation, lowered body temperature, coma. Treatment—Symptomatic and supportive (gastric lavage; intravenous fluids; maintenance of blood pressure, body temperature, and adequate respiration). Dialysis may speed removal of barbiturates from body fluids.



Dosage: 50-200 mg. (¾-3 grains) at bedtime.

[031767]

Additional information available to physicians upon request.
Eli Lilly and Company • Indianapolis, Indiana 46206

700955

Lilly

DIARRHEA



CANTIL®
(mepenzolate bromide)

LAKESIDE

Diarrhea, one of the most vexing symptoms of common G. I. disorders can often be curbed with Cantil (mepenzolate bromide), bringing welcome relief to the harassed patient. Relatively specific for the hyperactive colon, it helps reduce diarrhea, pain and spasm with minimal effect on other viscera. Cantil (mepenzolate bromide) is indicated whenever these symptoms are associated with irritable colon, gastroenteritis, diverticulitis, and mild to moderate ulcerative colitis.

It is an anticholinergic drug without narcotic properties. Side effects are usually mild.

IN BRIEF: One or two tablets three times a day and one or two at bedtime usually provide prompt relief. Cantil with Phenobarbital may be prescribed if sedation is required.

Dryness of the mouth, blurring of vision, constipation, nausea, vomiting, bloating and dizziness may occur but are usually mild and transitory. Urinary retention is rare. Caution should be observed in prostatic hypertrophy — withhold in glaucoma. Contraindicated in patients sensitive to phenobarbital and/or Cantil (mepenzolate bromide); in toxic megacolon, obstruction of G. I. or G. U. tract.

SUPPLIED: CANTIL (mepenzolate bromide) — 25 mg. per scored tablet. Bottles of 100 and 250. CANTIL with PHENOBARBITAL — containing in each scored tablet 16 mg. phenobarbital (warning: may be habit forming) and 25 mg. mepenzolate bromide. Bottles of 100 and 250.

LAKESIDE LABORATORIES, INC., Milwaukee, Wisconsin 53201



Ninety-Third Annual Meeting

The prime requisite for having your "Guest Editorial" read is to be brief. This requisite will be met.

This critique of the 93rd Annual Meeting of the Florida Medical Association is presented by a non-officer, non-delegate, rank and file member of the Association. It is the common man's viewpoint.

The meeting was held at the Americana Hotel in Bal Harbour amidst the clamor of several other conventions, hubbub created by hundreds of tourists and the inconvenience of travel in a highly congested area. It is a sad commentary that Florida does not afford large enough convention facilities in any area other than the vicinity of Miami Beach.

The meeting was saddened at its onset by the death of Dr. Homer L. Pearson Jr., one of our past presidents and one of the most loved and respected men in the history of Florida medicine.

By Friday evening, the registration desk reported 900 registrants, or less than 20% of the membership. A large influx was expected on the following day to attend the various specialty societies' business and scientific sessions.

At the Blue Shield meeting, an unprecedented event occurred when several nominations were made from the floor for elections to the Blue Shield Board. One of the floor nominees was elected. It has often been said that we need new blood and new energy to evolve from the membership. This apparently was an attempt to break up this somewhat self-perpetuating body. Certainly no one can deny that there are many needed changes due in Blue Shield.

The House of Delegates met on Thursday morning and the various reference committees met that afternoon without other conflicting meetings. This is an example of excellent scheduling, but it should be carried to its ultimate possibility by scheduling the various reference committees at separate times. This could be accomplished by deleting some of the unnecessary formality at the first meeting of the House of Delegates and scheduling the reference committee meetings on into Thursday night.

The Friday scientific session presented many interesting papers but had an attendance that was extremely poor with less than 100 members and guests in the audience at several papers. The guest speaker at the general session was the Honorable Claude Kirk, Governor of the State of Florida, who presented a rather witty speech which was highlighted by the naming of members to a health advisory council to the Governor's office. Most of those named are from the same group which usually performs a major portion of the work in FMA.

The scientific exhibits were well presented. More of these exhibits should be encouraged to present new advances and ideas to our membership. The technical exhibits were much a repetition of the exhibits in past years with the exception that we Camel smokers no longer get free cigarettes because lung cancer is a dread disease, possibly related to smoking.

I regret having had to leave before the specialty sessions on Saturday. I am sure, however, that those who were interested attended the sessions, and the disinterested are not reading this report, anyhow.

FMA leadership would be wise to review the recommendations made by Drs. Glenn and Connar in their 1965 editorials regarding improvements of the annual meetings.

Our newly elected President, Dr. W. Dean Steward of Orlando, is a most efficient organizer and extremely hard worker. We look for improvements in the coming year.

E. B. Hardee Jr., M.D.
Vero Beach

National and Regional Meetings in Florida

August

American Academy of Physical Medicine & Rehabilitation, Americana Hotel, Miami Beach, Aug. 27-Sept. 1.

American Association of Electromyography and Electrodiagnosis, Americana Hotel, Miami Beach, Aug. 27.

American Congress of Rehabilitation Medicine, Americana Hotel, Miami Beach, Aug. 27-Sept. 1.

September

American Society for Colposcopy and Colpomicroscopy, Americana Hotel, Miami Beach, Sept. 28-Oct. 3.

October

American Association of Public Health Physicians, Miami Beach, Oct. 23-27.

American College of Preventive Medicine, Fontainebleau Hotel, Miami Beach, Oct. 22-23.

American Orthotics and Prosthetics Association, Fontainebleau Hotel, Miami Beach, Oct. 7-11.

American Public Health Association, Fontainebleau Hotel, Miami Beach, Oct. 23-27.

American School Health Association, Miami, Oct. 21-26.

November

Gerontological Society, Princess Martha Hotel, St. Petersburg, Nov. 9-11.

American College of Preventive Medicine, Fontainebleau Hotel, Miami Beach, Nov. 10-14.

Southern Medical Association, Miami Beach, Nov. 13-16.

National Federation of Catholic Physicians' Guild, Miami, Nov. 9-11.

Meetings

Approved by FMA Committee on Postgraduate Education

August

6- 9 Alcoholic Rehabilitation Program. Fifth Annual Florida School of Alcohol Workshop, Seville Hotel, Miami Beach.

17-19 Postgraduate Obstetric-Pediatric Seminar, Daytona Plaza Hotel, Daytona Beach.

September

16-17 Sixth Annual Physician's Seminar on Respiratory Diseases, Hotel Robert Meyer, Jacksonville.

22-23 Cardiovascular-Radiology Seminar, J. Hillis Miller Health Center, Gainesville.

October

21 Duval County Medical Society, Seminar on Shock, Hotel Roosevelt, Jacksonville.

26-28 Today's Hospital Problems: An Interdisciplinary Approach, Tides Hotel and Bath Club, Redington Beach.

27-28 Infectious Diseases Seminar, J. Hillis Miller Health Center, Gainesville.

November

13-17 Selected Topics in Cardiology, Mt. Sinai Hospital of Greater Miami Auditorium, Miami Beach.

16-17 Obstetrics & Gynecology Seminar, J. Hillis Miller Health Center, Gainesville.

January

4- 7 Recent Advances in Local Anesthetics and Regional Anesthesia, Eden Roc Hotel, Miami Beach.

24-25 Obstetrics & Gynecology Seminar, J. Hillis Miller Health Center, Gainesville.

March

2 Current Medical Concepts, Watson Clinic, Lakeland.

THE DUVALL HOME for RETARDED CHILDREN

A home offering the finest custodial care with a happy home-like environment. We specialize in the care of infants, bed-ridden children and Mongoloids.

For further information write to

MRS. A. H. DUVALL GLENWOOD, FLORIDA

Deaths

Alexander, Robert Martin, West Palm Beach; born in New York City, Jan. 12, 1920; Tulane University School of Medicine, 1944; served an internship at King's County Hospital and residencies at Brooklyn State Hospital and the Veterans Administration Hospital, Dayton, Ohio; came to West Palm Beach in 1953 and engaged in the practice of internal medicine; served in the U.S. Army Medical Corps from 1956 to 1958, attaining the rank of captain; held membership in the American Medical Association and the Southern Medical Association; died January 24, aged 47.

Calhoon, Jay Walter, Fort Lauderdale; born in Zanesville, Ohio, March 8, 1898; Ohio State University College of Medicine, 1921; served an internship at St. Clair Hospital, Columbus, Ohio; engaged in the general practice of medicine in the cities of Byesville and Uhrichsville, Ohio, before coming to Fort Lauderdale in 1963; served as president and as secretary of the Tuscarawas County Medical Society, Ohio, and as a state delegate and a member of the State Legislative Committee for the Ohio State Medical Association; was a charter member of the American Academy of General Practice and held membership in the Ohio State Medical Association; died February 7, aged 68.

Cameron, Fay A., Tampa; born in Winchester, Tenn., Oct. 30, 1884; Medical College of South Carolina, 1909; came to Tampa in 1910 and engaged in the general practice of medicine; served in the Hillsborough County Health Department from 1937 to 1957; retired in 1957; was a life member of the Florida Medical Association; died February 1, aged 82.

Cook, Henry Mac, Tampa; born in Lecta, Ala., Aug. 25, 1886; Atlanta College of Physicians and Surgeons (Emory), 1910; interned at Tabernacle Infirmary, now Georgia Baptist Hospital, Atlanta; came to Tampa in 1912 and engaged in general practice and surgery until 1921, when he then limited his work to general surgery; during the summer of 1938 he did postgraduate work in surgery in Vienna, Austria; owned and operated Cook's Hospital, Tampa, for 42 years, retiring in 1961; was a life member of the FMA and held membership in the American Medical Association and Southern Medical Association; died March 12, aged 81.

Corlew, Edith Paula Mols, Tampa; born in Buffalo, N.Y., March 2, 1904; Woman's Medical College of Pennsylvania, 1930; served an internship and residency at Woman's Medical College of Pennsylvania; on the staff of the Florida State College for Women from 1930 to 1934; came to Tampa in 1934 where she engaged in the general practice of medicine; held membership in the American Medical Association, American Medical Women's Association and the Southern Medical Association; died March 17, aged 63.

Daniels, James Palace, Pensacola; born in Pensacola, Feb. 1, 1904; Tulane University School of Medicine, 1928; served an internship at Schumpert Hospital and a residency at Highland Hospital, both of Shreveport, La.; came to Pensacola in 1930 and engaged in the general practice of medicine; was on the staffs of Baptist, Escambia General and Sacred Heart Hospitals, all of Pensacola; held membership in the American Medical Association, Southern Medical Association, American Academy of General Practice and

Florida Academy of General Practice and was a Fellow of the American Society of Abdominal Surgeons; died April 9, aged 63.

Day, Horace Asa, Orlando; born in Treadway, Tenn., May 1, 1894; University of Cincinnati School of Medicine, 1923; interned at Cincinnati General Hospital and served residencies at St. Mary's Hospital, St. Louis, Mo. and Women's Hospital, New York City; came to Orlando and began the private practice of obstetrics, gynecology and general surgery in 1925; served as president of the Orange County Medical Society and as president of the Florida Association of Blood Banks; was chief of staff at Orange Memorial Hospital, Orlando; held membership in the American Medical Association, Southern Medical Association, Florida Blood Banks and Florida Obstetrics and Gynecology Association; died February 20, aged 72.

Donegan, Charles Coleman Jr., Fort Myers; born in Newport News, Va., 1924; University of Virginia School of Medicine, 1951; served an internship at the University of Virginia Hospital; practiced pediatrics four years in Huntington, N. Y.; moved to Naples where he practiced two years, then moved to Fort Myers in 1960; was assistant resident in pediatrics at the University of Virginia Hospital from 1953 to 1954 and became resident pediatrician in 1954; died March 16, aged 42.

Goodless, Maxwell David, Hollywood; born in Toronto, Canada, 1926; Toronto School of Medicine, 1950; came to Hollywood in 1956 from Flushing Hospital, Flushing, N.Y. and at the time of his death was chief of surgery at Memorial Hospital, Hollywood; held membership in the American Medical Association and the American College of Surgeons; died February 24, aged 41.

Hughes, John Ames, Fort Lauderdale; born in Newport News, Va., May 23, 1917; George Washington University School of Medicine, 1943; served an internship and residency at the George Washington University Hospital, Washington, D.C.; served in the U.S. Army Medical Corps where he attained the rank of lieutenant; came to Coral Gables in 1947 where he engaged in the private practice of internal medicine; was affiliated with Baptist, Jackson Memorial and South



Take five...

LABSTIX® provides 5 important urinary findings*—on a single reagent strip! That's *more* information than you can get from any other single reagent strip. You know the results in just 30 seconds—while the patient is still in your office—and readings are reliable and reproducible. LABSTIX is easy to handle, too. Never goes limp, even when wet, because it's made with clear, firm plastic. And results with LABSTIX are easy to read—color contrast between the test areas and the transparent plastic is clearly defined. An unexpected "positive" from testing with LABSTIX may help in detecting hidden pathology before marked symptoms are manifest.

*Blood; ketones; glucose; protein, and pH.

AMES COMPANY
Division Miles Laboratories, Inc.
Elkhart, Indiana 46514

Ames

Note: *AMERICAN HOSPITAL FORMULARY SERVICE CATEGORY NUMBER 36:88*

40167



...Plus one

You can extend your testing scope by including ICTOTEST® Reagent Tablets, the 30-second determination for bilirubinuria—which can be an early sign of obstruction of the common bile duct, infectious hepatitis, or other liver disease. This test is also useful for detecting liver damage from carbon tetrachloride and other halogenated hydrocarbons used as industrial and household solvents. Positive findings with the urine-testing team of LABSTIX and ICTOTEST can represent significant guides to patient management in many clinical situations. "Negatives" may help rule out suspected abnormalities over a broad clinical range and are important for the patient's record.

AMES COMPANY
Division Miles Laboratories, Inc.
Elkhart, Indiana 46514

Ames

Note: *AMERICAN HOSPITAL FORMULARY SERVICE CATEGORY NUMBER 36:88*

40167

Miami hospitals, all of Miami; held membership in the American Medical Association, Southern Medical Association, Aero Medical Association Pan Cytology Society and District of Columbia Medical Society; died Nov. 25, 1966, aged 49.

Johnston, Hewit, Orlando; born in Walker County Ala., Jan. 16, 1874; University of Nashville College of Medicine 1906; served an internship at City Hospital, Nashville, Tennessee; residencies at J. Hood Wright and Ruptured and Crippled Children's hospitals, both of New York City; engaged in the general practice of medicine in Walker and Jefferson counties, Alabama, 1906 to 1915, and in Biloxi, Miss., 1916 to 1917; served in the U.S. Army Medical Corps attaining the rank of captain; came to Orlando in 1922; served as president and as secretary of the Orange County Medical Society and as a member of the Florida Medical Association's House of Delegates for two terms and as a member of the FMA Economics Committee; was a Master Mason, a charter member of the Veterans of Foreign Wars; held membership in the American Medical Association, American Academy of Ophthalmology and Otolaryngology, Florida Society of Ophthalmology and Otolaryngology; died March 9, aged 93.

Nowling, James Cleveland, Jupiter; born in Chumuchla, Fla. March 17, 1888; Emory University School of Medicine, 1914; served an internship and residency at the Chicago University Hospital; came to West Palm Beach in 1931 where he engaged in the general practice of medicine; was a life member of the Florida Medical Association; held membership in the American Medical Association and Southern Medical Association; died April 8, aged 79.

Payton, Frazier James, Miami; born in Frankfort, Ind., August 21, 1896; Indiana University School of Medicine, 1925; interned at St. Anthony's Hospital, Terre Haute, Ind. and served residencies at Allison Hospital, Miami Beach and Howard A. Kelly Hospital, Baltimore, Md.; began the private practice of radiology in Miami in 1927; served during World War I as a lieutenant, U.S. Army Field Artillery and during World War II as a commander, U.S. Navy Medical Corps; served the FMA as member and chairman, Cancer Control Committee, as member and chairman, Florida Cancer Council and as a member of the

Membership and Discipline Committee; served as vice president of the Dade County Medical Association and on numerous committees of that Association; was a life member of the FMA, a founding member and past president, vice president, secretary and treasurer of the Florida Radiological Society; was a Diplomate of the American Board of Radiology and a Fellow of the Academy International of Medicine; held membership in the Radiological Society of North America, American College of Radiology and the Southern Medical Association; died March 1, aged 71.

Pines, John Andrew, Orlando; born in Boone, Iowa, July 15, 1879; University of Colorado School of Medicine, 1911; served residencies at the New England Sanitorium, Melrose, Mass., and the Florida Sanitorium and Hospital, Orlando; engaged in the general practice of medicine in Pallisades, Colo., 1911 to 1912, Garden City, Iowa 1912 to 1916, and Melrose, Mass., 1916 to 1919; came to Orlando in 1919; served as president and as secretary of the Orange County Medical Society; served as president of the Florida Radiological Society and held membership in the American Medical Association, American College of Radiology, American Board of Radiology, American Roentgen Ray Society and the Florida Radiological Society; died March 22, aged 87.

Snow, Thomas Austin, Gainesville; born in Walker County, Ala., June 8, 1893; University of Alabama Medical School, 1918; interned at Hillman Hospital, Birmingham, Ala. and served residencies at Carraway Methodist Hospital and University of Alabama Outpatient Clinic, both of Birmingham, Ala.; engaged in the general practice of medicine in Birmingham, Ala. from 1918 until 1927, when he moved to Gainesville; served two terms as president of the Alachua County Medical Society; was a life member of the FMA and held membership in the American Medical Association; died March 15, aged 74.

Stepner, A. Lester, Miami; born in Brooklyn, N.Y., Oct. 14, 1906; Eclectic Medical College, Cincinnati, Ohio, 1935; interned at St. Joseph's Infirmary, Louisville, Ky. and served residencies at Goldwater Memorial Hospital, New York City, Hillside Hospital, Glen Oaks, N. Y., and Bellevue Hospital, New York City; had practiced psychiatry in Miami since 1953; was a Fellow of the American Psychiatric Association, American Psychosomatic Society and Academy of Psychoanalysis and held membership in the American Medical Association and the Society of Medical Psychoanalysts; died January 21, aged 61.

Waldron, Barzillia Robbins, St. Petersburg; born in Califon, N.J., Jan. 20, 1910; New York Medical College, 1945; interned at the U.S. Navy Hospital, Mare Island, Calif.; served in the U.S. Navy Medical Corps for 21 months, mostly in the Far East; returned to study internal medicine at Bellevue Medical Center, N.Y.C., followed by a two-year residency at Queens Hospital, Long Island, N.Y. and later studied cardiovascular disease at Harvard Medical School, Boston, Mass.; practiced internal medicine in St. Petersburg since 1952; was a Fellow of the American College of Cardiologists and held membership in the American Heart Association; died March 17, aged 47.

SOCIETY	PRESIDENT	SECRETARY	MEETING DATE	TOTAL MEMBERS Associate	Active
Alachua	Carl E. Van Arnam, Gainesville	Taylor H. Kirby Jr., Gainesville	2nd Tues.	40	140
**Bradford, Gilchrist, Union*					
Bay	Theodore G. Elchos, Panama City	John F. Cluxton, Panama City	1st Tues.	0	41
Brevard	Daniel L. Donovan, Rockledge	Norman F. Fain Jr., Rockledge	2nd Tues.	11	140
Broward	Ray E. Murphy Jr., Ft. Lauderdale	Theodore W. Hahn, Ft. Lauderdale	4th Tues.	43	418
Charlotte	Fred P. Nisi, Port Charlotte	Carl N. Reilly, Punta Gorda	2nd Tues.	0	12
Clay	Aubrey Y. Covington, Gr. Cove Spgs.	Hinson L. Stephens, Orange Park		0	13
Collier	Richard I. Brashear, Naples	Ethel H. Trygstad, Naples	3rd Wed.	1	25
Columbia	John T. Wilson, Lake City	Charles T. Ozaki, Lake City	3rd Wed.	0	15
Dade	Maurice M. Greenfield, Miami	Vincent P. Corso, Miami	1st Tues.	208	1,396
DeSoto-Hardee-Glades	Grant P. Carmichael, Wauchula	Ernest P. Palmer, Wauchula	1st Tues.	2	17
Duval	William A. Van Nortwick, J'ville	Gordon H. Ira Jr., Jacksonville	1st Tues.	38	420
Escambia	William M. C. Wilhoit, Pensacola	Theodore J. Marshall, Pensacola	2nd Tues.	3	134
Franklin-Gulf	Photis J. Nichols, Apalachicola	J. Wayne Hendrix, Port St. Joe	Last Wed.	1	4
Gadsden-Liberty	John M. Griffin, Quincy	Robert P. C. Whittier, Quincy	Quarterly	1	13
Highlands	Santford R. Boley, Sebring	Samuel A. King, Avon Park	3rd Mon.	2	23
Hillsborough	Collin F. Baker Jr., Tampa	Rodney D. Steinmetz, Tampa	1st Tues.	8	326
Indian River	Robert H. Vinson, Vero Beach	Hampton L. Schofield Jr., Vero Beach	2nd Tues.	0	24
Jackson-Calhoun	Elga B. White, Blountstown	Francis M. Watson, Marianna	1st Wed.	0	18
Lake	Frederick C. Hester III, Eustis	Thomas H. Nichols, Clermont	1st Wed.	2	44
Lee-Hendry	Fred J. Burford, Ft. Myers	Robert R. Tate, Cape Coral	3rd Mon.	4	73
Leon-Wakulla-Jefferson	Stuart C. Smith, Tallahassee	Frank E. All, Tallahassee	1st Mon.	6	87
Madison	Thomas G. Bouland Jr., Madison	William J. Bibb, Madison	1st Tues.	1	5
Manatee	Albert A. Simkus, Bradenton	Donn W. Keels, Bradenton	2nd Tues.	4	59
Marion	Charles H. Marks, Ocala	West Bitzer, Ocala	3rd Tues.	6	46
**Levy*					
Monroe	Joseph J. Scarlet, Key West	Jaime M. Benavides, Key West	1st Thurs.	1	22
Nassau	Cecil B. Brewton, Fernandina Bch.	John B. Britton, Fernandina Bch.	2nd Thurs	3	9
**Baker*					
Okaloosa	Malcolm C. Crotzer, Ft. Walton Bch.	Hildreth V. Anderson II, Ft. Walton Beach	1st Wed.	0	23
Orange	Edward W. Stoner, Orlando	Paul C. Harding, Orlando	3rd Wed.	42	326
**Osceola*					
Palm Beach	Carl E. Andrews, W. Palm Beach	Bernard Kimmel, W. Palm Beach	4th Mon.	27	278
Pasco-Hernando-Citrus	James W. Basinger, Dade City	W. Wardlaw Jones, Dade City	2nd Thurs.	4	28
**Sumter*					
Pinellas	Abbott Y. Wilcox Jr., St. P'burg	William H. Keeler III, St. P'burg	1st Mon.	71	389
Polk	Gordon R. Heath, Lakeland	Woods A. Howard, Lakeland	2nd Wed.	17	185
Putnam	Thelbert R. Suggs, Crescent City	David R. Young, Palatka	2nd Tues.	2	13
St. Johns	George C. Hopkins, St. Augustine	Vernon A. Lockwood, St. Augustine	3rd Tues.	0	20
St. Lucie-Okeechobee-Martin	Clem C. Benton, Ft. Pierce	Robert C. Dimmett, Ft. Pierce	3rd Thurs.	3	44
Santa Rosa	Elbert W. Sutton, Milton	Claude J. Barnes, Milton	3rd Tues.	6	11
Sarasota	Eugene J. Boyd, Sarasota	Samuel O. Sager, Sarasota	2nd Tues.	13	124
Seminole	Thomas L. Largen, Sanford	Nelson E. Cabrera, Sanford	2nd Tues.	0	26
Suwannee-Hamilton-LaFayette	Frederick T. Mickler Jr., Jasper	James F. Dietrich, Live Oak	1st Sat.	0	7
Taylor	T. Conrad Williams Jr., Perry	John A. Dyal Jr., Perry	Last Fri.	0	8
**Dixie*					
Volusia	Russell L. Welsh, Daytona Bch.	Thomas D. Cook, Daytona Beach	2nd Tues.	7	127
**Flagler*					
Walton	Charles J. Roehm, DeFuniak Spgs.	McKinley Cheshire Jr., DeFuniak Spgs.	3rd Tues.	0	8
Washington-Holmes	John T. Grace, Bonifay	James B. Craven, Chipley	Quarterly	0	5
			Total	577	5,146
			Grand Total	5,723	

Schedule of Meetings

ORGANIZATION	PRESIDENT	SECRETARY	ANNUAL MEETING
Florida Medical Association	W. Dean Steward, Orlando	Floyd K. Hurt, Jacksonville	Hollywood, May 8-12, 196
Florida Specialty Societies			
Allergy Society	George Gittelson, Miami	Melvin Newman, Jacksonville	
Anesthesiologists, Soc. of	John A. Rush Jr., Jacksonville	Richard C. Hartsfield, Jacksonville	
Chest Phys., Am. Coll., Fla. Chap.	Harold C. Spear, Miami	Charles H. Lasley, Clearwater	
Dermatology, Society of	Helen L. Dexter, Clearwater	Arnold R. Goddard, Coral Gables	
General Practice, Academy	Louis C. Murray, Orlando	William P. Clarke, Jacksonville	
Internal Medicine	Robert E. Raborn, Delray Beach	Abbott Y. Wilcox Jr., St. Petersb'g	
Neurology, Florida Society of	J. Robert Campbell, Tampa	Francis L. Merritt, Lakeland	
Neurosurgical Society	Purdue L. Gould, West Palm Bch.	Howard C. Chandler, Jacksonville	
Obst. & Gynec. Society	William T. Mixson Jr., Coral Gbls.	Joseph W. Pilkington, St. Petersb'g	
Ophthalmology Society	James W. Clower Jr., D'tona Bch.	Charles F. McCrory, Jacksonville	
Orthopedic Society	Leon H. Mims Jr., Coral Gables	Robert J. Pfaff, Lakeland	
Otolaryngology Society	Bernard M. Barrett, Pensacola	West Bitzer, Ocala	
Pathologists, Society of	Laudie E. McHenry Jr., Melb. Bch.	William F. Mahoney, Sarasota	
Pediatric Society	James M. Weaver, Ft. Lauderdale	Ray O. Edwards Jr., Jacksonville	
Phys. Med. & Rehab., Fla. Soc.	Sterling H. Huntington, Coral Gbls.	Bruce B. Sutton, Coral Gables	
Plastic & Reconstr. Surg.	Thomas J. Baker, Miami	Robert L. Wells, St. Petersburg	
Preventive Medicine, Fla. Soc.	Charles C. Flood, Vero Beach	E. Charlton Prather, Orange Park	
Proctologic Society	George Williams Jr., Miami	John T. McCormick, Jacksonville	
Psychiatric Society	William C. Ruffin Jr., Gainesville	Arnold H. Eichert, Hollywood	
Radiological Society	Andre S. Capi, Fort Lauderdale	Malcolm S. Van de Water, P. Bch.	
Surgeons, Am. Coll., Fla. Chap.	Richard G. Connar, Tampa	Harry W. Reinstine Jr., J'ville	
Surgeons, Gen., Fla. Assn.	Robert E. Zellner, Orlando	Jesse W. Castleberry, Orlando	
Surgeons, Int. Coll., Fla. Chap.	Eldridge W. Johnson, Orlando	Wendell J. Newcomb, Pensacola	
Urological Society	Carey N. Barry, Fort Myers	Victor A. Politano, Miami	

(Most Specialty Group meetings are scheduled at the time of the annual meeting of the Association)

FLORIDA			
American Cancer Society, Div.	Donald W. Smith, M.D., Miami	Mrs. Peggy Lombardo, J'ville	November 1967
Arthritis Foundation, Chap.	Mr. John S. Knotts, Daytona Bch.	Miss Barbara White, G'ville	April 1968
Basic Science Examining Board	Paul A. Vestal, Ph. D., Winter Pk.	Theodore A. Ashford, Ph.D. 1832 Bearss Ave., Tampa 33612	Miami, Nov. 4, '67
Blood Banks, Association	A. Ralph Monaco, M.D., Panama City	Dorothy C. Smith, R.N., J'ville	Pensacola, Apr. 26-28, '68
Blue Shield of Florida, Inc.	Warren W. Quillian, M.D., Coral Gables	Henry J. Babers Jr., M.D., Gainesville	Hollywood, May 8-12, '68
Board of Medical Examiners	Scottie J. Wilson, M.D., Ft. Lauderdale	Leo Grossman, M.D., Miami P.O. Box 5, Biscayne Annex, Miami 33152	Jacksonville, Jan. 14-16,
Crippled Children & Adults, Soc.	Mr. Bruce Thomason, Gainesville	Mrs. Page Hufty, Palm Beach	Miami, Fall of 1967
Diabetes Association	Matthew E. Morrow, M.D., Jacksonville	Robert T. Rengarts, M.D., Sebring	Miami Beach, Sept. 28-30
Heart Association	Louis Lemberg, M.D., Miami	John M. Packard, M.D., Pensacola	Miami, June 5-9, '68
Mental Health, Association for	Moke W. Williams, M.D., Ft. Lauderdale	Mrs. R. R. Littrell, Sarasota	Cocoa Beach, Apr. 25-27,
National Foundation	Mr. Basil O'Connor, New York	Mr. Ed. Foreman, Orlando	April 1968
Nat'l Multiple Sclerosis Soc.	Mr. Harold W. Comfort, New York	Mr. Robert E. McWeeney, Hollywood	Minneapolis, Minn., Oct
Prevention of Blindness, Soc.	Mr. R. B. Matthews, Coral Gables	Mrs. Richard Nosti, Tampa	Jacksonville, Nov. 18, '67
Public Health Association	William R. Stinger, M.D., Miami	Mrs. Margaret McLendon, J'ville	Miami Beach, Oct. 22-26,
Retarded Children, Association	Mr. Marion P. Smith, Clearwater	Mrs. Jane Riedel, Cocoa	Clearwater, May 9-12, '68
Thoracic Society	Asher Marks, M.D., Miami	Edward W. Swenson, M.D., Gainesville	April 1968
Tuberculosis & Res. Dis. Assn.	Mr. R. A. Caruthers, Orlando	Mr. C. W. Lantz, Hollywood	April 1968
United Cerebral Palsy of Florida	Mr. John P. Hilburn, Tampa	Mr. Harry Botwick, Miami	November 1967
Woman's Auxiliary	Mrs. Russell B. Carson, Ft. Lauderdale	Mrs. Linus W. Hewit, Tampa	Hollywood, May 8-12, '68
American Medical Association	Charles L. Hudson, M.D., Cleveland	F. J. L. Blasingame, M.D., Chicago	San Francisco, June 16-20
A.M.A. Clinical Session			Houston, Nov. 26-29, '67

Index to Advertisers

Abbott Laboratories
Erythrocin Sulfas 632-634

Ames Co., Inc.
Ictotest 731
Labstix 730

Anderson Surgical Supply Co. 726

Appalachian Hall 724

Ayerst Laboratories
Mediatric 640-641

Ballast Point Manor 725

Bristol Laboratories
Prostaphlin 622-623
Tetrex F. 630

Burroughs-Wellcome Co.
Neosporin 680a

Convention Press 726

Duvall Home 728

Gebauer Chemical Co.
Ethyl Chloride 726a

Geigy Pharmaceuticals
Ducolax 718a
Tandearil 634-634a

Glenbrook Laboratories
Bayer Aspirin 718

Guild of Prescription Opticians 626

Highland Hospital, Inc. 714

Hill Crest Hospital 726

Hynson, Westcott & Dunning, Inc.
BSP Disposable Unit 619

Lakeside Laboratories, Inc.
Cantil 726a

Lederle Laboratories
Aristocort 723
Tine Test 714
Stresscaps 631

Eli Lilly & Co.
Co-Pyronil 642
Ilosone 680a
Tuinal 726a
V-Cillin K 634a

Medical Supply Co. 715

William S. Merrell Co.
Alertonic 638-639

Parke-Davis & Co.
Benadryl Second Cover

Pitman-Moore Co.
Novahistine LP 717

P. L. Dodge Memorial Hospital 725

PM of Florida 715

William P. Poythress & Co.
Mudrane 629
Solfoton 628

A. H. Robins, Inc.
Ambar 718a

Roche Laboratories
Librium Back Cover

Wm. H. Rorer, Inc.
Novestrol 624-625

Sandoz Pharmaceuticals
Mellaril 680a

G. D. Searle Co.
Flagyl 680a

Stuart Co.
Mylanta 713

Surgical Supply Co. 725

Syntex Laboratories
Norinyl-1 719-722

Tucker Hospital, Inc. 724

S. J. Tutag
Aquatag 715

Wyeth Laboratories
Serax 636-637
Tubex 626a

Wynn Pharmaceuticals, Inc.
Numa Dura-Tabs 620

Florida Medical Association

1967-1968

Officers, Councils and Committees

OFFICERS

W. DEAN STEWARD, M.D., President Orlando
JACK Q. CLEVELAND, M.D.,
President-Elect Coral Gables
IRVING E. HALL JR., M.D.,
Vice President Bradenton
JAMES T. COOK, M.D.,
Speaker of the House Marianna
CHARLES K. DONEGAN, M.D.,
Vice Speaker St. Petersburg
FLOYD K. HURT, M.D.,
Secretary-Treasurer Jacksonville
GEORGE S. PALMER, M.D.,
Immediate Past President Tallahassee

EXECUTIVE DIRECTOR

W. HAROLD PARHAM Jacksonville

BOARD OF GOVERNORS

W. DEAN STEWARD, M.D.,*
Chm., Ex Officio Orlando
JACK Q. CLEVELAND, M.D.,*
(President-Elect) Ex Officio Coral Gables
IRVING E. HALL JR., M.D.,
(Vice President) Ex Officio Bradenton
JAMES T. COOK, M.D., (Speaker
of the House) Ex Officio Marianna
FLOYD K. HURT, M.D.,* (Secretary-
Treasurer) Ex Officio Jacksonville
GEORGE S. PALMER, M.D.,*+ ... PP-69 ... Tallahassee
H. PHILLIP HAMPTON, M.D., ... PP-68 ... Tampa
JOHN J. CHELEDEN, M.D., ... AL-68 ... Daytona Beach
WILLIAM M. C. WILHOIT, M.D., ... A-70 ... Pensacola
WILLIAM J. DEAN, M.D.,* ... B-71 ... St. Petersburg
CHARLES R. SIAS, M.D., ... C-69 ... Orlando
RICHARD M. FLEMING, M.D., — D-68 ... Miami Beach
BURNS A. DOBBINS, M.D., ... AMA
Delegate-68 ... Ft. Lauderdale
EUGENE G. PEEK JR., M.D., ... SBH-68 ... Ocala

*Executive Committee
+Public Relations Officer

COUNCIL ON ALLIED PROFESSIONS AND VOCATIONS

JESSE W. CASTLEBERRY, M.D., Chm. Orlando

DENTISTRY

WILLIAM M. DOUGLAS, M.D., Chm. .. C-71 Orlando
GROVER W. AUSTIN, M.D., .. AL-68 St. Petersburg
W. ROY HANCOCK, M.D., .. A-68 Jacksonville
ARGIN A. BOGGUS, M.D., .. B-70 Tavares
JAMES G. ROBERTSON, M.D. .. D-69 Miami

LAW

HILBERT A. P. LEININGER, M.D.,
Chm. .. D-71 Coral Gables
AMOS L. PREVATT, M.D., .. AL-68 Pensacola
GERALD D. N. BRYANT, M.D., .. A-70 Tallahassee
JAMES R. BOULWARE JR., M.D., .. B-69 Lakeland
CARROLL M. CROUCH, M.D., .. C-68 Daytona Beach

MEDICAL ASSISTANTS

WOODS A. HOWARDS, M.D., Chm. .. AL-68 Lakeland
SAMUEL J. ALFORD, M.D. .. A-71 Jacksonville
JAMES M. STEM, M.D., .. B-70 Clearwater
FRED H. ALBEE JR., M.D., .. C-69 Daytona Beach
JAMES L. ANDERSON, M.D. .. D-68 Miami

MEDICAL TECHNOLOGISTS

MILLARD B. WHITE, M.D., Chm. .. B-71 Sarasota
LAUDIE E. McHENRY JR., M.D.,
AL-68 Melbourne Beach
SANFORD A. MULLEN, M.D. .. A-70 Jacksonville
HAMPTON L. SCHOFIELD JR., M.D.,
C-69 Vero Beach
JOHN B. MIALE, M.D. .. D-68 Miami

NURSING

JAMES W. WALKER, M.D., Chm. .. A-68 Jacksonville
CHARLES H. GILLILAND, M.D., .. AL-68 Gainesville
JOHN M. BUTCHER, M.D., .. B-69 Sarasota
THOMAS C. KENASTON JR., M.D., .. C-71 Cocoa
JAMES J. HUTSON, M.D., .. D-70 Miami

PHARMACY

BEN C. STOREY, M.D., Chm. .. C-71 Titusville
THOMAS D. WEAVER, M.D., .. AL-68 Clermont
GRETCHEN V. SQUIRES, M.D., .. A-68 Pensacola
JOSEPH A. EZZO, M.D., .. B-69 St. Petersburg
M. JAY FLIPSE, M.D., .. D-70 Miami

PHYSICAL THERAPY

WILLIAM J. HUTCHISON, M.D.,
Chm. .. AL-68 Tallahassee
JOSEPH C. SHIPP, M.D., .. A-68 Gainesville
ARTHUR J. PASACH, M.D., .. B-69 Tampa
LOUIS J. NOVAK, M.D., .. C-70 Hollywood
STERLING H. HUNTINGTON, M.D., .. D-71 .. Coral Gables

RELIGION

G. DEKLE TAYLOR, M.D., Chm. .. AL-68 Jacksonville
GRETCHEN V. SQUIRES, M.D., .. A-69 Pensacola
SIDNEY GRAU, M.D., .. B-70 St. Petersburg
CURTIS D. BENTON JR., M.D., .. C-71 Ft. Lauderdale
CORREN P. YOUMANS, M.D., .. D-68 Miami

VETERINARY MEDICINE

CLIFFORD C. SNYDER, M.D., Chm. .. D-71 ... Coral Gables
JOHN H. PARKER JR., M.D., .. AL-68 Perry
GEORGE W. KARELAS, M.D., .. A-70 Newberry
IRWIN S. LEINBACH, M.D., .. B-69 St. Petersburg
JAMES C. RINAMAN, M.D. .. C-68 St. Cloud

RADIOLOGIC AND NUCLEAR MEDICINE TECHNOLOGISTS

EDWARD C. BURNS JR., M.D., Chm. .. AL-68 .. Lake Wales
ALEXANDER GOULARD JR., M.D., .. A-69 Ocala
BYRON E. BESSE JR., M.D., .. B-68 Tampa
HERBERT D. KERMAN, M.D., .. C-70 Daytona Beach
WILLIAM J. WINTER JR., M.D., .. D-71 Miami

JUDICIAL COUNCIL

JOHN J. CHELEDEN, M.D., Chm. Daytona Beach

ARCHIVES

WILLIAM M. STRAIGHT, M.D., Chm. .. D-70 Miami
ROWLAND E. WOOD, M.D. .. AL-68 St. Petersburg
JOSEPH P. HENDRIX, M.D., .. A-71 Port St. Joe
W. WARDLAW JONES, M.D., .. B-69 Dade City
HUGH WEST, M.D. .. C-68 DeLand

GRIEVANCE

ROBERT E. ZELLNER, M.D., Chm. Orlando
WARREN W. QUILLIAN, M.D. Coral Gables
SAMUEL M. DAY, M.D. Jacksonville
H. PHILLIP HAMPTON, M.D. Tampa
GEORGE S. PALMER, M.D. Tallahassee

MEDICAL LICENSURE

COURTLANDT D. BERRY, M.D., Chm. Orlando
SCOTTIE J. WILSON, M.D. Ft. Lauderdale
LEO GROSSMAN, M.D. Miami

MEMBERSHIP AND DISCIPLINE

District 1—WILLIAM C. ROBERTS, M.D., .. 71 *Panama City*
J. WAYNE HENDRIX, M.D.,..70..*Port St. Joe*
District 2—WILLIAM C. THOMAS SR., M.D., .. 68 *Gainesville*
JAMES T. COOK, M.D., .. 69, Chm. ..*Marianna*
District 3—THOMAS M. IRWIN, M.D., .. 70 ..*Jacksonville*
HUGH A. CARITHERS, M.D.,..71..*Jacksonville*
District 4—W. WARDLAW JONES, M.D., .. 68 ..*Dade City*
JOHN J. CHELEDEN, M.D....70..*Daytona Beach*
District 5—THOMAS C. KENASTON SR., M.D....69 *Cocoa*
FRANK C. BONE, M.D., .. 71*Orlando*
District 6—ERNEST R. BOURKARD, M.D., .. 68 ..*Tampa*
C. FRANK CHUNN, M.D., .. 69*Tampa*
District 7—GORDON H. McSWAIN, M.D., .. 71 ...*Arcadia*
JOHN M. BUTCHER, M.D., .. 70*Sarasota*
District 8—EDWARD L. COLE JR., M.D., .. 69 *St. Petersburg*
N. WORTH GABLE, M.D...68...*St. Petersburg*
District 9—WILLIAM H. PROCTOR, M.D., .. 70 *West Palm Beach*
MYRL SPIVEY, M.D., .. 71 ..*West Palm Beach*
District 10—MILES J. BIELEK, M.D., .. 71 ..*Ft. Lauderdale*
RUSSELL B. CARSON, M.D., .. 69 *Ft. Lauderdale*
District 11—EDWARD J. LAUTH JR., M.D., .. 68*Miami*
HAROLD RAND, M.D., .. 70*Miami*
District 12—JACK Q. CLEVELAND, M.D., .. 69*Miami*
NELSON ZIVITZ, M.D., .. 68*Miami Beach*

COUNCIL MEMBER FROM BOARD OF PAST PRESIDENTS

H. PHILLIP HAMPTON, M.D.*Tampa*

COUNCIL ON LEGISLATION AND PUBLIC AGENCIES

JERE W. ANNIS, M.D., Chm.*Lakeland*

STATE LEGISLATION

EDWARD G. HASKELL JR., M.D., Chm. .. A-70 *Tallahassee*
FRANK E. WILLIAMS, M.D., .. AL-68*Cantonment*
JOHN E. OREBAUGH, M.D., .. B-71*St. Petersburg*
LOUIS C. MURRAY, M.D., .. C-69*Orlando*
ROBERT V. EDWARDS, M.D., .. D-68*Coral Gables*
Subcommittee—Liaison with State Agencies:
FRANCIS T. HOLLAND, M.D., Chm.*Tallahassee*
SIMON D. DOFF, M.D., Commission on Aging ..*Jacksonville*
PAUL S. JARRETT, M.D., Alcoholic Rehabilitation ...*Miami*
EUGENE G. PEEK JR., M.D., Board of Health*Ocala*
MARION W. HESTER, M.D., Council for the Blind *Lakeland*
FRANCIS T. HOLLAND, M.D., Crippled Children's Commission*Tallahassee*
CHARLOTTE C. MAGUIRE, M.D., Division of Child Training*Orlando*
RAYMOND J. FITZPATRICK, M.D., Division of Correction*Gainesville*
WILLIAM M. C. WILHOIT, M.D., Division of Mental Health*Pensacola*
WESLEY S. NOCK, M.D., Education Department *Coral Gables*
THOMAS J. BIXLER, M.D., Industrial Commission*Tallahassee*
ARTHUR W. WOOD JR., M.D., Insurance Department *Miami*
JERE W. ANNIS, M.D., Public Welfare*Lakeland*
LAWRENCE E. GEESLIN, M.D., Tuberculosis Board*Jacksonville*
WILLIAM H. EVERTS, M.D., Vocational Rehabilitation*West Palm Beach*

NATIONAL LEGISLATION

JOSEPH C. VON THRON, M.D., Chm.*Cocoa Beach*
JERE W. ANNIS, M.D.*Lakeland*
H. PHILLIP HAMPTON, M.D.*Tampa*
PHILIP B. PHILLIPS, M.D.*Pensacola*
EDWARD G. HASKELL JR., M.D.....*Tallahassee*
SAMUEL M. DAY, M.D.*Jacksonville*
EUGENE G. PEEK JR., M.D.*Ocala*
CHARLES R. SIAS, M.D.*Orlando*
ROBERT W. WITHERS, M.D.*Tampa*
MELVIN M. SIMMONS, M.D.*Sarasota*
ALLYN B. GIFFIN, M.D.*St. Petersburg*
DAVID W. MARTIN, M.D.*West Palm Beach*
ANDRE S. CAPI, M.D.*Ft. Lauderdale*
JACK Q. CLEVELAND, M.D.*Coral Gables*
FRANKLIN J. EVANS, M.D.*Coral Gables*
Subcommittee—Liaison with Federal Agencies:
ROY E. CAMPBELL, M.D., Chm.*Palatka*
FRANK B. HODNETTE, M.D., Department of Defense*Pensacola*
JERE W. ANNIS, M.D., Department of Health, Education and Welfare*Lakeland*
ROBERT H. MICKLER, M.D., Department of Justice*Tallahassee*
THOMAS J. BIXLER, M.D., Department of Labor*Tallahassee*
ROY E. CAMPBELL, M.D., Veterans Administration *Palatka*

COUNCIL ON MEDICAL ECONOMICS

JACK A. MaCRIS, M.D., Chm.*St. Petersburg*

ADVISORY TO BLUE SHIELD & FISCAL INTERMEDIARIES

MYRL SPIVEY, M.D., Chm. .. C-71.....*West Palm Beach*
FRED A. BUTLER, M.D., .. AL-68.....*Naples*
JAMES D. BEESON, M.D., .. A-68.....*Jacksonville*
EDSON J. ANDREWS, M.D., .. A-69.....*Tallahassee*
RAYMOND J. FITZPATRICK, M.D., A-70*Gainesville*
ALFRED L. LEWIS, M.D., .. A-71.....*Tallahassee*
IRVING M. ESSRIG, M.D.....B-68.....*Tampa*
RALPH C. AYE, M.D., .. B-69.....*Tampa*
JOHN C. FLETCHER, M.D., .. B-70.....*Tampa*
HENRY G. MORTON, M.D., .. B-71.....*Sarasota*
LOUIS C. MURRAY, M.D., .. C-68.....*Orlando*
JACK T. BECHTEL, M.D., .. C-69.....*Indialantic*
JOHN R. MAHONEY, M.D., .. C-70.....*Ft. Lauderdale*
H. HOFFMAN GROSKLOSS, M.D., D-68*Coral Gables*
HOLLIS F. GARRARD, M.D., .. D-69.....*Miami*
RICHARD C. CLAY, M.D., .. D-70.....*Miami*
JAMES L. ANDERSON, M.D.,.. D-71.....*Miami*

HEALTH INSURANCE

ARTHUR W. WOOD JR., M.D., Chm. .. AL-68*Miami*
BILLY BRASHEAR, M.D...A-68.....*Gainesville*
GEORGE H. WELCH JR., M.D...B-71*St. Petersburg*
ARTHUR L. EBERLY, M.D...C-70.....*Pompano Beach*
CHARLES A. MONNIN JR., M.D...D-69.....*Miami*

HOSPITALS AND EXTENDED CARE FACILITIES

VERNON B. ASTLER, M.D., Chm. .. AL-68 ..*Boynton Beach*
JOSEPH L. RUBEL, M.D...A-69.....*Pensacola*
EDWARD W. SALKO, M.D...B-71.....*Ft. Myers*
ALBERT F. STRATTON JR., M.D...C-68.....*Cocoa*
ROBERT F. DICKEY, M.D...D-70.....*Miami*

MEMBERS INSURANCE

W. ROY HANCOCK, M.D., Chm...A-68.....*Jacksonville*
H. LAWRENCE SMITH, M.D...AL-68.....*Tallahassee*
WILLIS W. HARRIS, M.D...B-71.....*Bradenton*
RUSSELL D. D. HOOVER, M.D...C-69....*West Palm Beach*
H. CLINTON DAVIS, M.D...D-70.....*Miami*

RELATIVE VALUE STUDIES

FRED A. BUTLER, M.D., Chm...B-71.....*Naples*
STUART C. SMITH, M.D...AL-68.....*Tallahassee*
JAMES A. CRANFORD JR., M.D...A-69.....*Jacksonville*
EMMET F. FERGUSON JR., M.D., .. A-70*Jacksonville*
CHARLES K. DONEGAN, M.D...B-70.....*St. Petersburg*
JOSEPH G. MATTHEWS, M.D...C-68.....*Orlando*
WILLIAM E. HOFFMEISTER, M.D., .. C-71 ..*Winter Park*
DUARD LAWRENCE, M.D...D-68.....*Miami*
T. D. SANDBERG, M.D...D-69.....*Coral Gables*

COUNCIL ON MEDICAL SERVICES

JAMES M. INGRAM, M.D., Chm.....*Tampa*

AGING

SIMON D. DOFF, M.D., Chm...AL-68.....*Jacksonville*
CHARLES J. KAHN, M.D...A-70.....*Pensacola*
JAMES A. WINSLOW JR., M.D...B-69.....*Tampa*
CLARENCE M. GILBERT, M.D...C-68.....*Orlando*
CHARLES R. BEBER, M.D...D-71.....*Miami*

BLOOD

FAIRFAX E. MONTAGUE, M.D., Chm...AL-68.....*Palatka*
GERARD H. HILBERT, M.D...A-70.....*Pensacola*
FRANK H. DeLAND, M.D...B-69.....*Lakeland*
JOHN H. MICKLEY, M.D...C-71.....*Hollywood*
O. WHITMORE BURTNER, M.D...D-68.....*Miami*

CHILD HEALTH

WESLEY S. NOCK, M.D., Chm...D-70.....*Coral Gables*
J. BASIL HALL, M.D...AL-68.....*Tavares*
ALVYN W. WHITE JR., M.D...A-69.....*Pensacola*
ADRIAN Q. POLLOCK, M.D...B-68.....*Ft. Myers*
IRWIN T. TAYLOR, M.D...C-71.....*Winter Park*

EMERGENCY MEDICAL SERVICE

JAMES L. CAMPBELL JR., M.D., Chm...C-68.....*Orlando*
A. T. KENNEDY, M.D...AL-68.....*Pensacola*
SAMUEL J. ALFORD JR., M.D...A-68.....*Jacksonville*
JOHN M. BUTCHER, M.D...B-68..... ..*Sarasota*
JOSEPH S. STEWART, M.D...D-68.....*Miami*

HEARING

JOHN H. WEBB, M.D., Chm...C-68.....*Orlando*
GEORGE T. SINGLETON, M.D...AL-68.....*Gainesville*
WILLIAM F. SHIPMAN JR., M.D...A-70.....*Tallahassee*
THOMAS M. EDWARDS, M.D...B-69.....*Tampa*
JAMES R. CHANDLER JR., M.D...D-71.....*Miami*

LABOR

LAURENT P. LaROCHE, M.D., Chm...AL-68....*Cocoa Beach*
ALBERT E. McQUAGGE, M.D...A-68.....*Marianna*
GEORGE J. SUAREZ, M.D...B-71.....*Tampa*
THEODORE J. KAMINSKI, M.D...C-70.....*Melbourne*
JAMES J. HUTSON, M.D...D-69.....*Miami*

MATERNAL HEALTH

FRANK M. PARISH, M.D., Chm...AL-68.....*Orlando*
JAMES P. McNEIL JR., M.D...A-70.....*Jacksonville*
T. VERNON FINCH, M.D...B-68.....*Sarasota*
GROVER C. McDANIEL JR., M.D...C-69....*Ft. Lauderdale*
GUILLERMO A. PUENTE-DUANY, M.D...D-71.....*Miami*

MENTAL HEALTH

JAMES W. ETTINGER, M.D., Chm...C-68.....*Rockledge*
MERTON L. EKWALL, M.D...AL-68.....*Tallahassee*
WILLIAM M. C. WILLHOIT, M.D...A-70.....*Pensacola*
ZACK RUSS JR., M.D...B-69.....*Tampa*
EDWARD H. WILLIAMS, M.D...D-71.....*Coral Gables*

MENTAL RETARDATION

CHARLOTTE C. MAGUIRE, M.D., Chm...C-68.....*Orlando*
C. JENNINGS DERRICK, M.D...AL-68....*West Palm Beach*
CHARLES R. BENTON, M.D...A-70.....*Pensacola*
RAY C. WUNDERLICH JR., M.D...B-71.....*St. Petersburg*
HERMAN SELINSKY, M.D...D-69.....*Miami Beach*

OCCUPATIONAL HEALTH

THOMAS B. THAMES, M.D., Chm...C-68.....*Orlando*
LAURENT P. LaROCHE, M.D...AL-68.....*Cocoa Beach*
SAMUEL S. LOMBARDO, M.D...A-69.....*Jacksonville*
CHARLES LARSEN JR., M.D...B-70.....*Lakeland*
JAMES J. HUTSON, M.D...D-71.....*Miami*

PUBLIC HEALTH

CLARENCE L. BRUMBACK, M.D.,
Chm...C-68.....*West Palm Beach*
FREDERICK C. ANDREWS, M.D...AL-68.....*Mount Dora*
JOHN B. BRITTON, M.D...A-69.....*Fernandina Beach*
ALBERT B. McCREARY, M.D...B-71.....*St. Petersburg*
JOHN D. MILTON, M.D...D-70.....*Coral Gables*

RURAL HEALTH

J. BASIL HALL, M.D., Chm...C-70.....*Tavares*
LAWRENCE G. HEBEL, M.D...AL-68.....*Palatka*
GEORGE W. KARELAS, M.D...A-68.....*Newberry*
FORREST HINTON, M.D...B-71.....*Immokalee*
RALPH E. CROSS, M.D...D-69.....*Homestead*

VISION

WILLIAM H. ANDERSON JR., M.D., Chm...A-71*Ocala*
G. BROCK MAGRUDER, M.D...AL-68.....*Orlando*
JOSEPH W. TAYLOR JR., M.D...B-70.....*Tampa*
CURTIS D. BENTON JR., M.D...C-69*Fort Lauderdale*
ALFRED G. SMITH II, M.D...D-68.....*Coral Gables*

COUNCIL ON SCIENTIFIC ACTIVITIES

RICHARD C. DEVER, M.D., Chm.....*Miami*

THE JOURNAL AND OTHER PUBLICATIONS

THAD MOSELEY, M.D., Editor.....*Jacksonville*
JOHN M. PACKARD, M.D., Assistant Editor.....*Pensacola*
OSCAR W. FREEMAN, M.D., Assistant Editor.....*Orlando*
JACK Q. CLEVELAND, M.D., Assistant Editor
from the Board of Governors.....*Coral Gables*

MEDICAL SCHOOLS

HENRY J. BABERS JR., M.D., Chm...A-71,
Alachua County Medical Society.....*Gainesville*
HENRY H. GRAHAM, M.D...AL-68.....*Gainesville*
SORRELL L. WOLFSON, M.D...B-69.....*Tampa*
FRED WALLS JR., M.D...C-68.....*Orlando*
EDWARD W. CULLIPHER, M.D...D-70,
Dade County Medical Association.....*Miami*
HAYDEN C. NICHOLSON, M.D., Faculty,
University of Miami.....*Miami*
SAMUEL P. MARTIN, M.D., Faculty,
University of Florida.....*Gainesville*

POSTGRADUATE EDUCATION

RICHARD G. CONNAR, M.D., Chm...B-70.....*Tampa*
JAMES J. DeVITO, M.D...A-71.....*St. Augustine*
MATTHEW E. MORROW JR., M.D...AL-68....*Jacksonville*
CHARLES J. COLLINS, M.D...C-69.....*Orlando*
WILLIAM W. CLEVELAND, M.D...D.68.....*Miami*

RESEARCH

KARL B. HANSON, M.D., Chm...A.....*Jacksonville*
DONALD W. SMITH, M.D...AL.....*Miami*
MILLARD B. WHITE, M.D...B.....*Sarasota*
MARTIN G. GOULD, M.D...C.....*Ft. Pierce*
JAMES J. GRIFFITTS, M.D...D.....*Miami*

SCIENTIFIC ASSEMBLIES

RUSSELL B. CARSON, M.D., Chm...C-69....*Ft. Lauderdale*
CHARLES K. DONEGAN, M.D...AL-68*St. Petersburg*
GEROLD L. SCHEIBLER, M.D...A-68.....*Gainesville*
EDWIN T. LONG, M.D...B-71*Lakeland*
JEROME H. MODELL, M.D...D-70.....*Miami*

COUNCIL ON SPECIAL ACTIVITIES

JOHN D. MILTON, M.D., Chm.....*Coral Gables*

ADVISORY TO WOMAN'S AUXILIARY

LEE ROGERS JR., M.D., Chm...C-68.....*Rockledge*
RUSSELL B. CARSON, M.D...AL-68.....*Ft. Lauderdale*
GORDON H. IRA, M.D...A-71.....*Jacksonville*
EUGENE B. MAXWELL, M.D...B-69*Tampa*
PERRY D. MELVIN, M.D...D-70.....*Miami*

BOARD OF PAST PRESIDENTS

JOHN D. MILTON, M.D., Chm...1955.....*Coral Gables*
GEORGE S. PALMER, M.D., Secy...1966.....*Tallahassee*
WILLIAM M. ROWLETT, M.D...1933.....*Tampa*
ORION O. FEASTER, M.D...1936.....*Long Beach, Miss.*
EDWARD JELKS, M.D...1937.....*Jacksonville*
WALTER C. JONES, M.D...1941.....*Miami*
EUGENE G. PEEK SR., M.D...1943.....*Ocala*
WILLIAM C. THOMAS SR., M.D...1945.....*Gainesville*
JOSEPH S. STEWART, M.D...1948.....*Miami*
WALTER C. PAYNE SR., M.D...1949.....*Pensacola*
ROBERT B. McIVER, M.D...1952.....*Jacksonville*
FREDERICK K. HERPEL, M.D...1953..*Laguna Hills, Calif.*
DUNCAN T. McEWAN, M.D...1954.....*Orlando*
FRANCIS H. LANGLEY, M.D...1956.....*St. Petersburg*
WILLIAM C. ROBERTS, M.D...1957.....*Panama City*
JERE W. ANNIS, M.D...1958.....*Lakeland*
RALPH W. JACK, M.D...1959.....*Miami*
LEO M. WACHTEL, M.D...1960.....*Jacksonville*
ROBERT E. ZELLNER, M.D...1962.....*Orlando*
WARREN W. QUILLIAN, M.D...1963.....*Coral Gables*
SAMUEL M. DAY, M.D...1964.....*Jacksonville*
H. PHILLIP HAMPTON, M.D...1965.....*Tampa*

A.M.A. HOUSE OF DELEGATES

ROBERT E. ZELLNER, M.D., Delegate.....*Orlando*
RALPH W. JACK, M.D., Alternate.....*Miami*
(Terms expire Dec. 31, 1967)
BURNS A. DOBBINS JR., M.D., Delegate....*Ft. Lauderdale*
WALTER E. MURPHREE, M.D., Alternate.....*Gainesville*
(Terms expire Dec. 31, 1967)
REUBEN B. CHRISMAN JR., M.D., Delegate...*Coral Gables*
SAMUEL M. DAY, M.D., Alternate.....*Jacksonville*
(Terms expire Dec. 31, 1968)
FRANCIS T. HOLLAND, M.D., Delegate.....*Tallahassee*
MADISON R. POPE, M.D., Alternate.....*Plant City*
(Terms expire Dec. 31, 1968)
JERE W. ANNIS, M.D., Delegate.....*Lakeland*
LEO M. WACHTEL, M.D., Alternate.....*Jacksonville*
(Terms expire Dec. 31, 1968)

COUNCIL ON SPECIALTY MEDICINE

SANFORD A. MULLEN, M.D., Chm.....*Jacksonville*

COMMITTEES

Anesthesiology—
JAMES D. BEESON, M.D...1971.....*Jacksonville*
Dermatology—
JACK H. BOWEN, M.D...1971.....*Jacksonville*
General Practice—
WALTER W. SACKETT JR., M.D...1969.....*Miami*
Internal Medicine—
CHARLES K. DONEGAN, M.D...1968....*St. Petersburg*
Neurosurgery—
THOMAS E. SCOTT JR., M.D...1970....*Daytona Beach*
Obstetrics and Gynecology—
CURTIS G. ROREBECK, M.D...1969.....*Tampa*

Ophthalmology and Otolaryngology—
JAMES W. CLOWER JR., M.D...1969....*Daytona Beach*
Orthopedics—
JOSEPH G. MATTHEWS, M.D...1971.....*Orlando*
Pathology—
SANFORD A. MULLEN, M.D...1968.....*Jacksonville*
Pediatrics—
J. ALFRED BOWERS, M.D...1968.....*Jacksonville Bch.*
Plastic Surgery—
BERNARD L. N. MORGAN, M.D...1969....*Jacksonville*
Psychiatry—
SAMUEL G. HIBBS, M.D...1971.....*Tampa*
Radiology—
ANDRE S. CAPI, M.D...1968.....*Ft. Lauderdale*
Surgery—
EMMET F. FERGUSON JR., M.D...1970....*Jacksonville*
Urology—
DAVID W. GODDARD, M.D...1970.....*Daytona Beach*

Subcommittee on Specialty Groups:

MELVIN NEWMAN, M.D.,
Florida Allergy Society.....*Jacksonville*
RICHARD C. HARTSFIELD, M.D.,
Florida Society of Anesthesiologists.....*Daytona Beach*
CHARLES H. LASLEY, M.D.
Florida Chapter, American College of
Chest Physicians.....*Clearwater*
ARNOLD R. GODDARD, M.D.,
Florida Society of Dermatology*Coral Gables*
WILLIAM P. CLARKE, M.D.,
Florida Academy of General Practice.....*Jacksonville*
ABBOTT Y. WILCOX JR., M.D.,
Florida Society of Internal Medicine.....*St. Petersburg*
FRANCIS L. MERRITT JR., M.D.,
Florida Society of Neurology.....*Lakeland*
HOWARD C. CHANDLER, M.D.,
Florida Neurosurgical Society.....*Jacksonville*
JOSEPH W. PILKINGTON, M.D.,
Florida Obstetric and Gynecologic Society....*St. Petersburg*
CHARLES F. McCRORY, M.D.,
Florida Society of Ophthalmology.....*Jacksonville*
ROBERT J. PFAFF, M.D.,
Florida Orthopedic Society.....*Lakeland*
WEST BITZER, M.D.,
Florida Society of Otolaryngology.....*Ocala*
WILLIAM F. MAHONEY, M.D.,
Florida Society of Pathologists.....*Sarasota*
RAY O. EDWARDS JR., M.D.,
Florida Pediatric Society.....*Jacksonville*
BRUCE B. SUTTON, M.D.,
Florida Society of Physical Medicine
and Rehabilitation.....*Coral Gables*
ROBERT L. WELLS, M.D.,
Florida Society of Plastic and
Reconstructive Surgery*St. Petersburg*
E. CHARLTON PRATHER, M.D., Florida Society of
Preventive Medicine.....*Orange Park*
JOHN T. McCORMICK, M.D.,
Florida Proctologic Society*Jacksonville*
ARNOLD H. EICHERT, M.D.,
Florida Psychiatric Society.....*Hollywood*
MALCOLM S. VAN de WATER, M.D.,
Florida Radiological Society.....*Windermere*
HARRY W. REINSTINE JR., M.D.,
Florida Chapter, American College
of Surgeons.....*Jacksonville*
JESSE W. CASTLEBERRY, M.D.,
Florida Association of General Surgeons.....*Orlando*
WENDELL J. NEWCOMB, M.D.,
Florida State Surgical Division,
International College of Surgeons.....*Pensacola*
VICTOR A. POLITANO, M.D.,
Florida Urological Society.....*Miami*

COUNCIL ON VOLUNTARY HEALTH AGENCIES

MASON ROMAINE III, M.D., Chm.....*Jacksonville*
MASON ROMAINE III, M.D.,
Florida Heart Association.....*Jacksonville*
LOUIS M. SALES, M.D., Florida Chapter,
The Arthritis Foundation.....*Jacksonville*
CHARLOTTE C. MAGUIRE, M.D., Florida Society
for Crippled Children and Adults.....*Orlando*
EARL E. WILKISON, M.D., Florida Division,
American Cancer Society.....*Tallahassee*
FRANK L. CREEL, M.D., Florida Association
for Mental Health.....*Pensacola*
HAWLEY H. SEILER, M.D., Florida Tuberculosis
and Respiratory Disease Association.....*Tampa*
THOMAS S. EDWARDS, M.D., Florida Society
for Prevention of Blindness.....*Jacksonville*
CHARLES H. CARTER, M.D., Florida Association
for Retarded Children.....*Orlando*
GORDON R. HEATH, M.D., United Cerebral
Palsy of Florida.....*Lakeland*
THEODORE A. DIPPY, M.D.,
The National Foundation.....*Winter Park*
RUTH A. RICE SIMONS, M.D.
National Multiple Sclerosis Society.....*Coral Gables*

FLORIDA MEDICAL FOUNDATION

EUGENE G. PEEK JR., M.D., President*Ocala*
WILLIAM J. DEAN, M.D., Vice President....*St. Petersburg*
FLOYD K. HURT M.D., Secretary-Treasurer....*Jacksonville*

INVESTMENT PLAN COMMITTEE

FLOYD K. HURT, M.D., Chm.....*Jacksonville*
BURNS A. DOBBINS JR., M.D.....*Ft. Lauderdale*
CARL S. McLEMORE, M.D.....*Orlando*
JOHN D. MILTON, M.D.....*Coral Gables*
WILLIAM M. C. WILHOIT, M.D.....*Pensacola*
JOHN M. BUTCHER, M.D.....*Sarasota*
JOHN J. CHELEDEN, M.D.....*Daytona Beach*
WILLIAM J. DEAN, M.D.....*St. Petersburg*
JAMES J. DeVITO, M.D.....*St. Augustine*
GEORGE S. PALMER, M.D.....*Tallahassee*
JOSEPH C. VON THRON, M.D.....*Cocoa Beach*
JAMES L. ANDERSON, M.D.....*Miami*

LEGAL COUNSEL

MARKS, GRAY, YATES, CONROY & GIBBS....*Jacksonville*

CERTIFIED PUBLIC ACCOUNTANTS

LUCAS, HERNDON, HARMS AND LUCAS....*Jacksonville*

Classified Advertisements

Advertising rates for this column are $5.00 per insertion for ads of 25 words or less. Add 20¢ for each additional word.

physicians wanted

General Practitioners

GENERAL PRACTITIONER WANTED (AAGP) for north Florida college town. Vacancy in busy two man practice in medicine, pediatrics and obstetrics. Immediate excellent income with eventual full partnership. Write C-614, P.O. Box 2411, Jacksonville, Fla. 32203.

EXCELLENT OPPORTUNITY for general practitioner in community of 15,000; central Florida; 76 bed JCAH hospital. Write or call collect R. C. Thompson, Bartow Memorial Hospital, Bartow, Fla.

WANTED: General practitioner associate, leading to partnership. Practice approximately one half industrial. Ideal central Florida community. Send detailed resume to C-716, P.O. Box 2411, Jacksonville, Fla. 32203.

GENERAL PRACTITIONER wanted to take over for physician going into residency. Beach community of 10,000; 50 bed hospital. Office and equipment available. Write C-745, P.O. Box 2411, Jacksonville, Fla. 32203.

GENERAL PRACTITIONER needed for independent practice within a three man association. Modern office building in Brooksville, Florida. Contains lab, x-ray and adequate personnel. Advantage of group practice without incumbrances of partnership. Call, write or visit R. A. Henry, M.D., Brooksville, Florida 33512.

WANTED: General practitioner to associate with established young doctor. Also office space available for rent. Contact G. L. Ehringer, M.D., 1184 Oceanshore Blvd., Ormond Beach, Florida 32074.

GENERAL PRACTITIONER WANTED: Partner, semi-rural practice in central Florida area undergoing rapid industrial expansion. Spacious, fully equipped office including x-ray. Good income without working yourself to death. Write C-749, P.O. Box 2411, Jacksonville, Fla. 32203.

WANTED: General practitioner and internist to join group for partnership in Miami area. Must have Florida license and fulfilled military obligation. Write Medical Business Consultants, 9999 N.E. 2nd Ave., Miami Shores, Fla. 33138.

WANTED: General practitioner (AAGP) for association in busy established practice. Fastest growing area in Florida. New Hospital. Office available. Liberal arrangements. Write Box 1957, Titusville, Fla. 32780.

Specialists

PEDIATRICIAN: Board eligible, to join two board pediatricians in rapidly growing Southeastern Florida coastal college town. Early partnership anticipated, excellent hospitals nearby. Send references and curriculum vitae in first letter. C-719, P.O. Box 2411, Jacksonville, Fla. 32203.

OBSTETRICIAN-GYNECOLOGIST WANTED: To associate with two man group. Large established practice in Miami; Board eligible or certified; prefer under age 35. Write P.O. Box 384, Miami Shores, Fla. 33153.

PEDIATRICIAN WANTED to locate in medical building on West Coast of Florida. Write C-761, P.O. Box 2411, Jacksonville, Fla. 32203.

PEDIATRICIAN: To join two pediatricians (shared expenses- individual practices). Must be board qualified, have Florida license, and under age 40. Choice city lower West coast. Write C-729, P.O. Box 2411, Jacksonville, Fla. 32203.

INTERNIST WANTED: Preferably young board qualified or certified internist to associate with well established certified internist in Ft. Lauderdale, Florida. Terms open. Send details first letter. Write C 752, P.O. Box 2411, Jacksonville, Fla. 32203.

INTERNIST WANTED: Recently completed Medical Arts building has vacancy for internist, Ormond Beach, Fla. Building now has medical laboratory, pharmacy, x-ray, general surgeon, gynecologist, general practitioner and an orthopod; most excellent opportunity. Write A. A. Monaco, M.D., Ormond Beach Medical Arts, 198 Vining Court, Ormond Beach, Fla. 32074.

NEUROLOGIST: A challenging opportunity for neurologist interested in Parkinsonism in facility devoted exclusively to this illness. Large number of Parkinson patients available daily. Excellent working conditions. Florida license required. Five day week. Fringe benefits. References required. Box 333, Miami, Florida 33101.

WANTED: Internist to associate with well established internist in Miami, Florida. Terms open. Write Lawson C. Johnson, M.D., 3298 Mary St., Miami, Fla. 33133.

real estate

UNUSUAL OPPORTUNITY: Pediatrician, otolaryngologist, general practitioner to locate in beach community. Complete suite in modern building with other physicians. Immediate medical support. Box 605, Melbourne, Fla. 32901.

MEDICAL OFFICE: Ultra-modern building. All services provided. Parking available. Five medical specialists, pharmacy, medical lab now installed. Space for one to three doctors. Write: New England Corporation, 240 New England Building, Winter Park, Fla. 32789. Telephone 644-8217.

AVAILABLE: Otolaryngology office. Immediate occupancy. Ideal location. Excellent opportunity. Capable gross $35,000-$50,000 first year. Owner retiring. Sell or lease. Location excellent for general practice. Write C-746, P.O. Box 2411, Jacksonville, Fla. 32203.

FOR RENT: Immediate occupancy, designed for internist. Ample parking, excellent location, 900 sq. ft. $225 monthly, lease available. Location: 1707 San Marco Blvd., Jacksonville. Contact Carl D. Langston, Inc., P.O. Box 8106, Jacksonville, Fla. 32211. Phone 724-8404.

OFFICE SPACE AVAILABLE in Medical-Dental Center. Well established GP leaving for specialized training. Orlando area. G. H. Culpepper, M.D. Hwy. 436, Altamonte Springs, Fla. 32701 or call (305) 838-3497.

MUST SACRIFICE: For sale or lease: 16 room medical clinic of deceased physician in northwest section of Miami. Fully equipped. Call UN4-0005 or UN5-9004 or write: Mrs. Barbara Pliskin, 7441 Wayne Ave., Miami Beach, Fla. 33141.

PHYSICIAN WANTED: Redington Beach's Plaza, Gulf Blvd. between 169th and 170th Avenues, N. Redington Beach. We will have available very shortly a 16 x 40 street level store which is now occupied by an osteopath. We are extremely short of doctors in this territory. Reasonable rent. Contact P.O. Box 8065, Madeira Beach, Fla. 33738.

FOR SALE OR RENT: Attractive, modern house, suitable small office in home. Ample space for expansion and parking. Prime corner location in Hollywood, visible main boulevard, zoned for practice. Five minutes from Memorial Hospital, excellent pharmacies adjacent. Write Lester A. Dahlin, P.O. Box 2211, Hollywood, Fla. 33022.

FOR LEASE: Quiet professional office available July 1, 1967. Presently set up for psychiatry, including group therapy room. On main thoroughfare near hospital and expressway. Ample parking. Write Mrs. Durrett, 1617 San Marco Boulevard, Jacksonville, Fla. 32207.

situations wanted

RELOCATION WANTED: Bored board general surgeon, Cleveland, wishes to relocate in Florida. Interested in solo, partnership or group practice. Now in practice. Age 45. Have Florida license. Write C-751, P.O. Box 2411, Jacksonville, Fla. 32203.

FLORIDA LICENSED resident at UF wishes to work for GP all or part of August. B. F. Davis, M.D., 3941 SW First Ave., Gainesville, Fla. 32601.

AVAILABLE FOR LOCUM TENENS OR ASSISTANT: Certified internist. January through May of each year. Florida license. Flexibility possible. Write C-759, P.O. Box 2411, Jacksonville, Fla. 32203.

Miscellaneous

NEEDED: Internist, general practitioner, pediatrician. Office can be built; night and weekend alternate call arrangement. For information contact Roy Campbell, M.D. or Walter Weigel, M.D., 310 South Palm Ave., Palatka, Fla. 32077.

WANTED: Assistant medical director for medium size Florida based life insurance company. Prefer physician under 40 with Florida license. Write C-760, P.O. Box 2411, Jacksonville, Fla. 32203.

EXPANDING MULTISPECIALTY CLINIC in Florida needs gastroenterologist, neurosurgeon, orthopedist, otolaryngologist, urologist. Seven man group, state capitol, two universities, 70,000 population. One hour drive to Panama City resort, beautiful rolling hills. Adequate salary first year then partnership. Will equip office. 250 bed hospital 500 ft. away. Resumé to Dr. Gerald N. Bryant, Medical Arts Clinic, Tallahassee, Fla. 32303.

OPPORTUNITY FOR DOCTORS who want to join a multi-specialty group—who want to practice in Florida. A senior surgeon with a large practice and with adequate facilities including laboratory, x-ray and physical therapy departments, desires to confer with board eligible or board certified doctors. The intent is to form a new multi-specialty group practice. Close proximity to a new 500 bed hospital. All inquiries held in strict confidence. Reply to: Jay S. Lombardy & Associates, Management to the Medical Profession, 1177 N.E. 8th St., Delray Beach, Florida 33444.

IMMEDIATE OPENING FOR FLORIDA LICENSED PHYSICIANS for the Emergency Room department. Excellent working conditions; salary open; fringe benefits. Contact Mr. S. A. Mudano, Administrator, Memorial Hospital, Hollywood, Florida 33021.

STUDENT HEALTH PHYSICIANS: Sept. 1967 openings for active young general practitioners, internists or pediatricians interested in adolescent medicine. Comprehensive student health service directed toward modern community health program. Affiliated with major University Medical Center in Southeast. Opportunity for teaching, research and faculty status if qualified. Compensation to $16,500 plus benefits. Enclose full resumé with first correspondence. Write C-762, P.O. Box 2411, Jacksonville, Fla. 32203.

Florida Medical Association
735 Riverside Ave., P. O. Box 2411
Jacksonville, Florida 32203

Information for Authors

Manuscripts submitted for publication in the Journal of the Florida Medical Association should be double or triple spaced on white bond, including title page, illustration legends, charts and graphs, table headings, footnotes and bibliography.

Submit original manuscript and two copies. Copying by electrostatic dry process (not wet process) is preferred to tissue copies. Retain one additional copy in your office for proofreading. All material is submitted with the understanding it is subject to editing.

Photographs should be submitted as 5x7 glossy prints, untrimmed and unmounted; number each photograph *lightly* on the back with pencil and indicate top. Charts, graphs and medical illustrations should be submitted as india ink drawings on white gloss paper; remember to make details large enough to allow for photographic reduction. It is a policy of the Journal that authors pay for any cuts made to illustrate their papers.

Titles should be short, specific and clear. Omit phrases such as "The Use of," "Observations on." If paper was presented at a meeting, indicate name of organization, city, month, day and year.

Only original papers not previously published are accepted for publication. Manuscripts submitted for publication are subject to review and approval by the Journal Publications Committee. Except by invitation, only papers from members of the Florida Medical Association are considered for publication.

References should be typewritten, double or triple spaced, beginning on a new sheet of paper entitled "References." Number references in the text in order of citation and prepare bibliography in the same order. Bibliographies should conform to the style of the Index Medicus. The Journal prints only bibliographies of eight references or less; bibliographies of more than eight references are referred to at the end of the paper with the statement "References are available from the author upon request."

All manuscript pages should be numbered consecutively. Within the manuscript, numbers one to nine should be spelled out except when used for units of measurement; for numbers above nine, numerals should be used. Dorland's Medical Dictionary and Webster's International Dictionary may be used as standard references. Scientific names for drugs should be used when possible. Copyright or trade names of drugs should be capitalized.

Index to Proceedings

Aesculapius Award 647
A. H. Robins Award 655
AMA-ERF Contributions 661
AMA Winter Meetings 687
Announcement of Reference Committee Meetings 656
Baldwin Lecture 647
Basic Science Examinations 696
Birth Certificates 673
Blood and Trade Laws 668
Blue Cross 702
Blue Shield 699, 702, 703
Board of Governors Report 677
By-Laws Amendments 681
Certificate of Appreciation 675
Certificate of Merit 674
Certification of Medical Necessity 694
Chiropractic 664
Continuing Education 663
Complimentary Coverage 664
Committee on Maternal Health 669
Committee on Rural Health 669
Council Reports
- Allied Professions and Vocations 666
- Judicial 683
- Legislation and Public Agencies 689
- Medical Economics 691
- Medical Education and Hospitals 662
- Medical Services 668
- Scientific 663
- Special Activities 685
- Specialty Medicine 663
- Voluntary Health Agencies 670

County Grievance Committees 685
Delegates
- First House 653
- Second House 660

Direct Billing 701
Disaster Committees 669
Emergency Room Coverage 683
Elections
- President Elect 706
- Vice President 707
- Speaker of the House 707
- Vice Speaker 708
- Secretary-Treasurer 708
- AMA Delegates and Alternates 708
- Committee on Membership and Discipline 709

Exhibit Visitation Awards 709
Family Planning 690
Farm Accident Prevention 669
First House of Delegates 653
FMA Policy Support 690
Franklin-Gulf County Medical Society 683
General Session 647
Governor's Steering Committee on Health 648
Hallucinatory Agents 669
Health Education 669
Health Insurance 669
Hearing Testing 669
Immunization 669
Individual Responsibility Policy 701
Internships 665
Judicial Council Rules 683
LSD 669
Medical Assistants Training 667
Medical Education 663, 665
Medical Technologists 673
Mental Retardation 669
Millis Report 665
Naturopathy 703
Optometrists 669
Oxygen Administration 669
Pathologists Defense 664
Physical Therapy Patients 698
Physician Reports Compensation 700
PKU Testing 669
Postgraduate Education 666
Presidents Address 643
Professional Liability 693
Professional Service Corporations 704
Reference Committee No. 1 662
Reference Committee No. 2 666
Reference Committee No. 3 673
Reference Committee No. 4 688
Relative Value Studies 663, 695
Remarks of the Speaker 655
Scientific Exhibit Awards 647
Second House of Delegates 660
Selective Service Commission 669
Shallow Wells 669
State Board of Health 704
State Fair Exhibit 687
Substitute Resolutions
- 3-8 Wilbur J. Cohen 672
- 19 Medical Education 665

Super-Regulatory Board 700
Third Medical School 663
Vision Screening 669
Washington-Holmes County Medical Society 683

Library
New York Academy of Medicine
2 East 103rd St
New York N Y J 12-67
10029

ANXIETY IS A SIGNIFICANT COMPONENT OF THE CLINICAL PROFILE

LIBRIUM®
(chlordiazepoxide HCl)

Also available as
LIBRITABS™ (chlordiazepoxide)
5-mg, 10-mg, 25-mg tablets

LIBRARY
JUL 20 1967
NEW YORK ACADEMY
OF MEDICINE

ROCHE

Before prescribing, please consult complete product information, a summary of which follows:

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver-function tests advisable during protracted therapy.

Usual Daily Dosage: Individualize for maximum beneficial effects. *Oral*—Adults: Mild and moderate anxiety and tension, 5 or 10 mg t.i.d. or q.i.d.; severe states, 20 or 25 mg t.i.d. or q.i.d. Geriatric patients: 5 mg b.i.d. to q.i.d. (See Precautions.)

Supplied: Librium® (chlordiazepoxide HCl) Capsules, 5 mg, 10 mg and 25 mg—bottles of 50. Libritabs™ (chlordiazepoxide) Tablets, 5 mg, 10 mg and 25 mg—bottles of 100. With respect to clinical activity, capsules and tablets are indistinguishable.

Roche Laboratories • Division of Hoffmann-La Roche Inc • Nutley, N.J. 07110

AUGUST, 1967
Volume 54
Number 8

The JOURNAL of the Florida Medical Association

1967 Historical Number

OFFICIAL PUBLICATION
OF THE
FLORIDA
MEDICAL ASSOCIATION



Whether the allergen is greenish or garish, unseen or unknown, your patient can get symptomatic relief with BENADRYL—the potent antihistamine with antispasmodic action. *INDICATIONS:* Antihistaminic, antispasmodic, antitussive, and antiemetic therapy. *PRECAUTIONS:* Persons who have become drowsy on this or other antihistamine-containing drugs, or whose tolerance is not known, should not drive vehicles or engage in other activities requiring keen response while using this product. Hypnotics, sedatives, or tranquilizers if used with diphenhydramine hydrochloride should be prescribed with caution because of possible additive effect. Diphenhydramine has an atropine-like action which should be considered when prescribing diphenhydramine hydrochloride. *ADVERSE REACTIONS:* Side effects are generally mild and may affect the nervous, gastrointestinal, and cardiovascular systems. Drowsiness, dizziness, dryness of the mouth, nausea, nervousness, palpitation, blurring of vision, vertigo, headache, muscular aching, thickening of bronchial secretions, restlessness, and insomnia have been reported. Allergic reactions may occur.

BENADRYL is available in Kapseals® of 50 mg. and Capsules of 25 mg. 00867

The pink capsule with the white band is a trademark of Parke, Davis & Company.

PARKE-DAVIS

Lutrexin®

HW&D BRAND OF LUTUTRIN

3000 UNIT TABLETS

IN THE TREATMENT OF FUNCTIONAL DYSMENORRHEA AND SELECTED CASES OF PREMATURE LABOR AND 2ND AND 3RD TRIMESTER THREATENED ABORTION

In controlling abnormal uterine activity, LUTREXIN, the non-steroid "uterine relaxing factor" has been found to be the drug of choice by many clinicians.

No side effects have been reported, even when massive doses (25 tablets per day) were administered.

Literature on indications and dosage available on request.

Supplied in bottles of twenty-five 3,000 unit tablets.

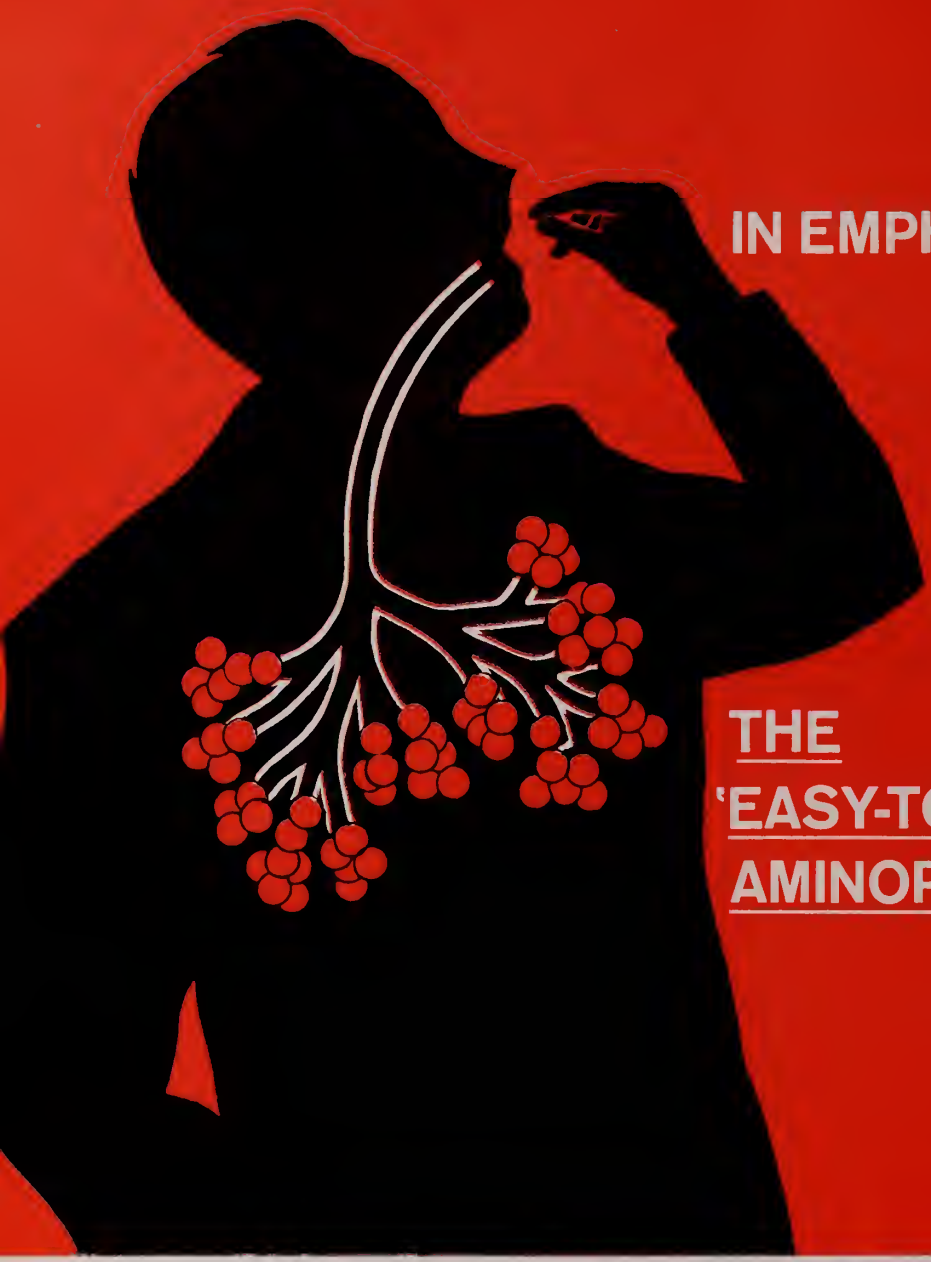
HYNSON, WESTCOTT & DUNNING, INC.

BALTIMORE, MARYLAND 21201 HW&D

(LTR22)



In vivo measurement of LUTREXIN (Lututrin) on contracting uterine muscle of the guinea pig.



IN EMPHYSEMA

THE 'EASY-TO-TAKE' AMINOPHYLLINE

Aminophylline dura-tabs®

prolonged-medication tablets 4½ gr. (0.3 Gm.)

Precautions: Use with caution in patients with poor renal function as a decreased rate of excretion may lead to accumulation and untoward reactions. Gastric irritation may occasionally be observed in certain patients sensitive to oral aminophylline.

Dosage: Adults, 1 to 2 Aminophylline Dura-Tabs each 8 or 12 hours, with food.

RARELY UPSET THE STOMACH

Oral aminophylline needn't disturb the stomach—nor a good night's sleep. Patients breathe easier all day, sleep better all night, as each Aminophylline Dura-Tab dose provides effective therapeutic activity for up to 12 hours. And unlike conventional tablets, AMINOPHYLLINE DURA-TABS seldom cause gastric distress. The special Dura-Tab process allows the gradual absorption of the medication from the intestinal tract with only a small fraction of the dose released in the stomach.

WYNN Pharmaceuticals, Inc. Phila., Pa. 19132 • Manufacturers of QUINAGLUTE® DURA-TABS®
(QUINIDINE GLUCONATE 5 gr.)

The JOURNAL
of the Florida Medical Association

Volume 54, Number 8, August 1967

THIS ISSUE

Historical Articles

Preface: Continuing a Tradition, Thad Moseley, M.D. 771
John Moultrie Jr., M.D., Joseph I. Waring, M.D. 772
'Old Timey' Remedies of Yesterday and Today, Max Michael Jr., M.D. and Mark V. Barrow, M.D. 778
Jackson Memorial Hospital: A Half Century of Community Service, William M. Straight, M.D. 785
John Gorrie, M.D., Edward Jelks, M.D. 797
Practice of Pathology in Florida 1908-1941, Alvan G. Foraker, M.D. and Lucien Y. Dyrenforth, M.D. 799
Joseph Yates Porter, M.D., Wilson T. Sowder, M.D. 801
History of Mental Health in Florida, Ann Spears Stover 809

Special Article

On Being Fifty, Ludd M. Spivey, D.D. 825

Editorial

Glimpses of Florida Medical History, William M. Straight, M.D. 755

Departments

President's Page 751
News 763
Letters 768
50 Years Ago in the Journal 819
National and Regional Meetings in Florida 822
Meetings 826
The Medical Detective 827
Association News 830
Public Health Topics 837
Classified 841

Miscellaneous

Florida Medical Association Officers and Council Chairmen 842
Information for Authors 842
Index to Advertisers 843

THAD MOSELEY, M.D.
Editor

Assistant Editors

JOHN M. PACKARD, M.D.
OSCAR W. FREEMAN, M.D.

Assistant Editor from the Board of Governors
JACK Q. CLEVELAND, M.D.

W. HAROLD PARHAM
Managing Editor

EUGENE L. NIXON
Associate Managing Editor

LOUISE RADER
Assistant Managing Editor

EDITH B. HILL
Editorial Consultant

ublished monthly at Jacksonville, lorida. Price $7.00 a year: single num-ers, 70 cents. Address Journal of lorida Medical Association, P.O. Box 11, 735 Riverside Ave., Jacksonville, la. 32203. Telephone (904) 356-1571. Ac-epted for mailing at special rate of ostage provided for in Section 1103, ct of Congress of October 3, 1917; uthorized October 16, 1918. Entered second class matter under Act of ongress of March 3, 1879, at the post fice at Jacksonville, Florida, October , 1924.

Owned and published by the Florida Medical Association, Inc. The Journal is not responsible for the opinions and statements of its contributors.



PRICED SO LOW YOU CAN'T SAY NO

Steal an hour, a day, a week—fishing, cruising, lazing. Plenty of room for family and friends. Enclosed cabin, 2 full-length bunks, marine head. Famous Stamas Level Ride in any water, at all speeds. All fiberglass. V-24 Clearwater is trailerable without special permits.

WRITE Dept. F for color brochures and nearest dealer. Stamas Boats are built in Florida; enjoyed all over the world.

Stamas BOATS, INC.
Tarpon Springs, Florida 33589

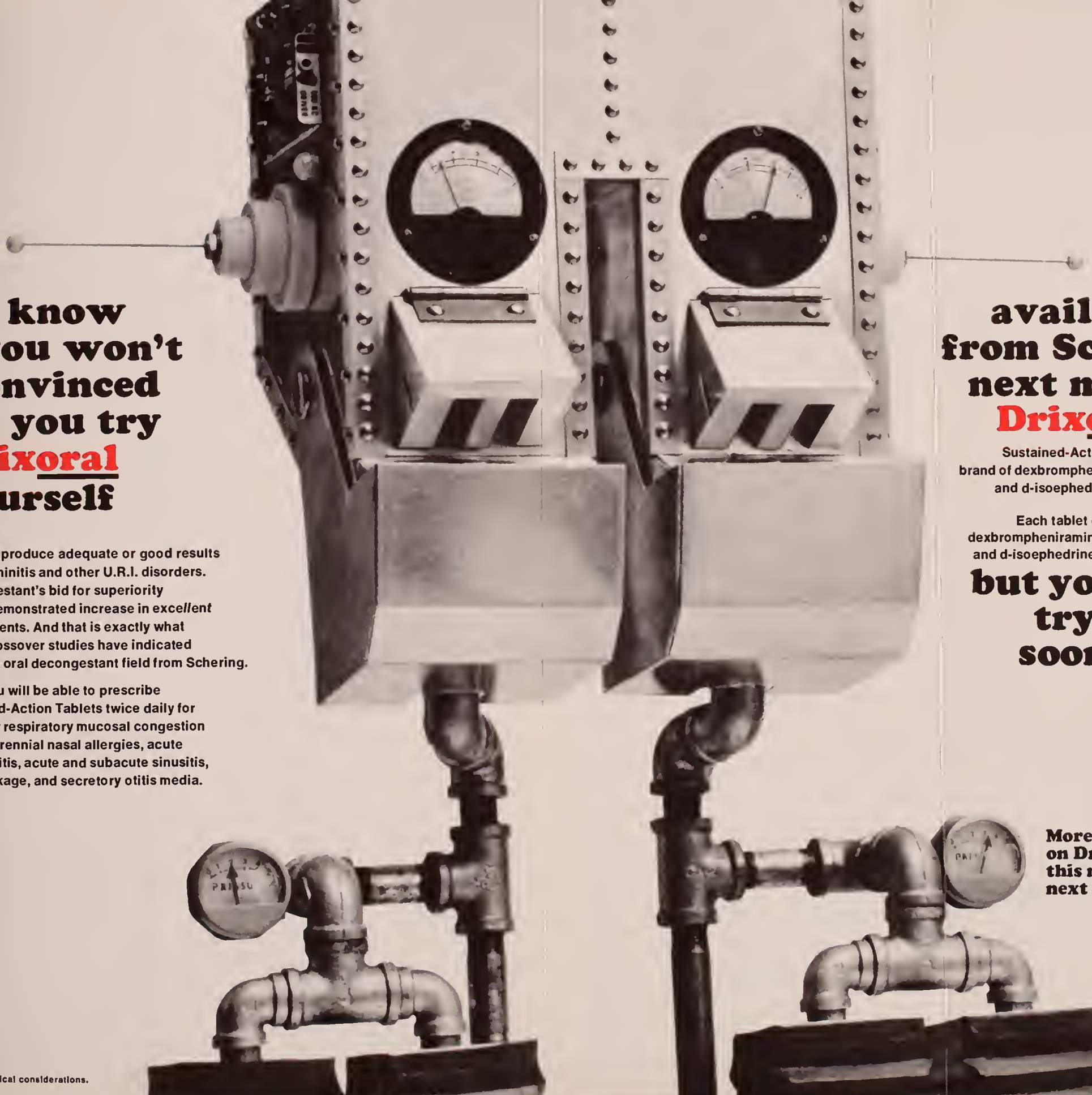


Schering

we know that you won't be convinced until you try Drixoral yourself

Most oral decongestants produce adequate or good results in most patients with rhinitis and other U.R.I. disorders. An oral decongestant's bid for superiority must be justified by a demonstrated increase in excellent results in *more* patients. And that is exactly what double-blind and crossover studies have indicated about a coming entry into the oral decongestant field from Schering.

Next month, you will be able to prescribe DRIXORAL Sustained-Action Tablets twice daily for 24-hour relief of upper respiratory mucosal congestion in seasonal and perennial nasal allergies, acute rhinitis and rhinosinusitis, acute and subacute sinusitis, eustachian tube blockage, and secretory otitis media.



available from Schering next month

Drixoral™

Sustained-Action Tablets
brand of dexbrompheniramine maleate and d-isoephedrine sulfate

Each tablet contains dexbrompheniramine maleate 6 mg., and d-isoephedrine sulfate 120 mg.

but you can try it sooner

More details on Drixoral and this mechanical man next month.

See last page of advertisement for clinical considerations.

Schering introduces Drixoral™



Double-blind and crossover studies[1-3] show superior results with an oral decongestant, but...

See last page of advertisement for clinical considerations.

see previous page for special pre-introductory sample offer for

New Drixoral™

Sustained-Action Tablets
brand of dexbrompheniramine maleate and d-isoephedrine sulfate

Each tablet contains dexbrompheniramine maleate 6 mg., and d-isoephedrine sulfate 120 mg.

Clinical considerations: Contraindications—DRIXORAL should not be given to children under 12 years of age. Until animal studies support the safety of this preparation for use during gestation, DRIXORAL should not be administered to pregnant women. *Precautions*—Although isoephedrine causes practically no pressor effect in normotensive individuals, it should be used with caution in patients with hypertension, coronary artery disease and hyperthyroidism. Dexbrompheniramine maleate may cause infrequent and usually mild drowsiness; should this occur, the patient should not engage in mechanical operations that require alertness. *Side effects*—Mild drowsiness has been observed in occasional patients receiving DRIXORAL. Although very infrequent complaints suggestive of sympathomimetic side effects have been noted, possible side effects of sympathomimetic origin include anxiety, tension, restlessness, nervousness, tremor, weakness, insomnia, headache, palpitation, tachycardia, angina, elevation of blood pressure, sweating, mydriasis, anorexia, nausea, vomiting, dizziness, constipation, and dysuria due to vesical sphincter spasm. For more complete details, consult package insert or Schering literature available from your Schering Representative or Medical Services Department, Union, New Jersey 07083.

References:
1. Pullen, F. W. 2nd, and Montgomery, W. W.: Arch. Otolaryng. 77:24, 1963.
2. Frank, D. I.: Curr. Therap. Res. 6:158, 1964.
3. Fierberg, A. A.: Ann. Allergy 22:324, 1964.

S-281



President's Page

Changing Trends

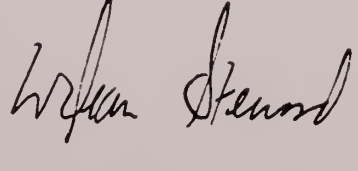
In a speech directed to the officers of component societies at the recent American Medical Association convention in Atlantic City, Paul Harvey, noted news commentator, stressed the need for medicine to have an articulate spokesman to present medicine's side of the recent and current changes in the philosophy of medical care. He ascribed part of the problem to the fact that news releases from government agencies always have a wide distribution, and often receive greater play than is indicated because of the source. Also, there is a minority of vocal physicians who are socialistically inclined and have access to high places.

Recently, press and radio releases about the increasing cost of medical care have been pointing the accusing finger toward the medical profession as the villain. In addition, veiled threats have been expressed if the physicians did not work to counteract further increases. Thinking individuals who are only partially informed know that the rising cost of hospitalization has been the major item in the increased cost of medical care. Seventy per cent of hospital costs were for labor before the recent increase in wages brought about by Administration edict. Now, labor costs produce an even larger portion of the hospital bill, and further rises are due in the next few years from extensions of the wage-hour law.

There also have been allegations that the medical profession was not cooperating or was even trying to sabotage the Medicare law by not accepting assignments, thus placing additional burdens on the elderly. The situation in Ohio has been so bad that the Ohio State Medical Association released a statement concerning it at the AMA annual convention. This is another example of the half truth—distortion—outright lie tactics that are being used to attempt to smear the medical profession and its good name. The speakers totally ignore the Medicare bill in which the physician is given the choice of billing procedures; it does not fit in with the plans of the socialist bureaucrats, so they tend to ignore it and try to lead the public to believe that the profession is not obeying the law.

Dr. M. O. Rouse, in his address after installation as AMA president, mentioned that we are faced with the concept of health care as a right rather than a privilege. This too has been quoted out of context, as was to be expected, to infer that if people could not afford medical care, they should do without. The history of medicine in America, the untold hours of free services rendered throughout this country, the physicians who have served on "S.S. Hope" and the volunteers for Vietnam all give the lie to this misquoted concept.

Because of the half truths and the distorted stories making the rounds, I am afraid I must disagree with Mr. Harvey. We do not need one spokesman; we need 300,000. In other words, every physician in private practice has the need to become informed of the true facts regarding the future of medicine in the United States if it goes the path planned by the bureaucrats in Washington. Furthermore, he has the *duty* to express himself to his patients, his friends, his newspaper and his county, state and national legislators. Only an aroused and informed electorate can save medicine and this country.





Perhaps there have been times when you wanted to prescribe erythromycin and triple sulfas for little patients. Now you can—with a choice of two new fine-tasting pediatric forms.

New–Two Pediatric Forms of Erythromycin and Triple Sulfas





ERYTHROCIN®-SULFAS Chewable (Erythromycin ethyl succinate-trisulfapyrimidines chewable tablet)

In clinical trials[1,2], this orange-flavored tablet was given to 55 patients, aged four months to 18 years.

Diagnoses (multiple in some cases) represented a cross section of bacterial infections commonly seen in pediatric office practice.

Therapy was given from three to 12 days, with an average of six days.

Of the 55 patients, 30 were reported cured within 72 hours, while 22 showed partial recovery within the same time, and subsequent clinical cure.

A clinical cure rate of 94.5%

ERYTHROCIN®-SULFAS Granules (Erythromycin ethyl succinate-trisulfapyrimidines granules for oral suspension)

87 patients were treated[1,2]—all children, ages four months to 15 years.

The diagnoses were multiple in some cases and were chiefly bacterial infections of the respiratory tract.

Dosage was maintained from three to 10 days; average treatment was five days. All of the ill children accepted the orange-flavored suspension favorably.

53 were clinically cured within 72 hours, while 32 showed partial relief within the same time, and subsequent clinical cure.

701358

A clinical cure rate of 97.7%

1. Case Reports on File, Dept. Clin. Development, Abbott Laboratories.
2. Polley, R.F.L., Use of Erythromycin-Sulfas in Office Practice, Western Med., 7:177, July, 1966.

ABBOTT

Brief Summary on next page

ERYTHROCIN®-SULFAS
Brief Summary

Contraindications: Known sensitivity to erythromycin or sulfonamides. Because of the possibility of kernicterus with sulfonamides, do not use in pregnancy at term, premature or newborn infants.

Warnings: As with other forms of sulfonamide therapy, carefully evaluate patients with liver or kidney damage, urinary obstruction, or blood dyscrasia. Deaths have been reported from hypersensitivity reactions and blood dyscrasias following use of sulfonamides. Perform blood counts and liver and kidney function tests if used repeatedly at close intervals or for long periods.

Precautions, Side Effects: Occasionally mild abdominal discomfort, nausea or vomiting may occur with erythromycin, generally controlled by reduction of dosage. Mild allergic reactions (such as urticaria and other skin rashes) may occur. Serious allergic reactions have been extremely infrequent. Use sulfonamides with caution in patients with a history of allergy. Assure adequate fluid intake to prevent crystalluria and institute alkali therapy if indicated. If overgrowth of nonsusceptible organisms occurs, withdraw the drug and institute appropriate treatment. If a patient should show signs of hypersensitivity, appropriate countermeasures (e.g. epinephrine, steriods, etc.) should be administered and the drug withdrawn.

Adverse Reactions: Sulfonamide therapy may be associated with headache, nausea, vomiting, urticaria, diarrhea, hepatitis, pancreatitis, blood dyscrasias, neuropathy, drug fever, skin rash, injection of the conjunctiva and sclera, petechiae, purpura, hematuria and crystalluria.

Side effects due to erythromycin are infrequent, but occasional abdominal discomfort, nausea, or vomiting, urticaria and other skin rashes may occur.

Supplied: The Granules for Oral Suspension come in bottles of 60 ml. and 150 ml. The Chewable tablets are in bottles of 50. Each 5-ml. teaspoonful of reconstituted Granules or each Chewable tablet provides erythromycin ethyl succinate equivalent to 125 mg. of erythromycin activity and 167 mg. of each of sulfadiazine, sulfamerazine and sulfamethazine.

701358

ABBOTT

Tandearil®
oxyphenbutazone

Tandearil in Painful Shoulder

Therapeutic Effects: Stiffness and pain may diminish within 2 days, and full mobility may be restored within a week. These effects are obtained with oxyphenbutazone alone or combined with physiotherapy or local hormonal injections. The drug is usually well tolerated and does not affect pituitary-adrenal function or immune response.

Contraindications: Edema; danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. The drug should not be given when the patient is senile or when other potent drugs are given concurrently.

Warning: If coumarin-type anticoagulants are given simultaneously, watch for excessive increase in prothrombin time. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea, sulfonamide-type agents and insulin. Carefully observe patients receiving such therapy. Use with great caution in the first trimester of pregnancy.

Precautions: Obtain a detailed history and a complete physical and laboratory examination, including a blood count. The patient should be closely supervised and should be warned to report immediately fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools or other evidence of intestinal hemorrhage. Make regular blood counts. Discontinue the drug and institute countermeasures if the white count changes significantly, granulocytes decrease, or immature forms appear. Use greater care in the elderly and in hypertensives.

Adverse Reactions: The most common are nausea, edema and drug rash. The drug has been associated with peptic ulcer and may reactivate a latent peptic ulcer. Infrequently, agranulocytosis, or a generalized allergic reaction may occur and require withdrawal of medication. Stomatitis, salivary gland enlargement, vomiting, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported but cannot definitely be attributed to the drug. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hyperglycemia, hepatitis, jaundice, and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently. Moderate lowering of the red cell count due to hemodilution may occur.

Dosage in Painful Shoulder: 600 mg. daily in divided doses for 2 to 3 days; 300 mg. daily thereafter. Usual duration of therapy: 2 to 7 days.

Availability: Tablets of 100 mg. 6562-VI(B)R

For complete details, please refer to full prescribing information.

Geigy

Geigy Pharmaceuticals
Division of Geigy Chemical Corporation
Ardsley, New York

Geigy

Tandearil® oxyphenbutazone helps painful shoulders move again



3 out of 4 painful shoulder patients responded well

84.2% of 127 patients

81% of 48 patients

Please see adjoining page for brief prescribing summary.

TA-5094PC

Sperling, I L
Applied Therap. 6 117. 1964
Rosenbaum, E E., and Schwarz, G R North-west Med. 61:927, 1962.


at the site of infection
(where it counts)...

Ilosone® provides more antibacterial activity than any other oral erythromycin

Acid stable, better absorbed... Ilosone produces faster, higher, more prolonged blood levels, even in the presence of food[1-3]

Because it is the most active form of oral erythromycin, Ilosone can help assure consistently greater antibacterial activity at the site of infection. Ilosone produces peak antibacterial blood levels two to four times those of other erythromycin preparations.[1,2] Not only are these levels attained earlier, but they are maintained for much longer periods. Even the presence of food does not seem to affect the activity of Ilosone.[1,3]

In the treatment of patients with bacterial infections susceptible to erythromycin, Ilosone has compiled an excellent therapeutic record. Since it exerts its greatest activity against gram-positive organisms, it is particularly useful in common respiratory and soft-tissue bacterial infections. Ilosone kills—not merely inhibits—streptococci, pneumococci, and more strains of staphylococci than any other macrolide antibiotic. This bactericidal action, coupled with the high antibacterial levels attained, makes Ilosone especially valuable in patients with low host resistance, such as infants, debilitated individuals, and diabetics.

Ilosone has shown no cross-resistance with penicillin and may be effective against organisms that have become resistant to that agent. Despite its high antibacterial activity, Ilosone has demonstrated a low incidence of side reactions. Blood dyscrasias, ototoxicity, and tooth staining have not been observed. Infrequent cases of drug idiosyncrasy, manifested by a cholestatic jaundice, have occurred, but there have been no known definite residual effects.

Now available:
New! Ready-mixed Ilosone Liquid 125! (Contains erythromycin estolate equivalent to 125 mg. erythromycin base per 5-cc. teaspoonful.)

700970

Ilosone®
Erythromycin Estolate

Lilly

(See next page for prescribing information.)

Ilosone®/ the most active oral form of erythromycin

Description: Ilosone is the most active form of oral erythromycin that has been developed. Because it is stable in acid, well absorbed, and excreted in lesser amounts in the bile, it provides faster, higher, and longer-lasting levels of antibacterial activity (ABA) in the serum, even when taken with food, than do comparable doses of erythromycin.

Indications: Ilosone is indicated in infections caused by microorganisms sensitive to its action (especially staphylococci, hemolytic streptococci, and pneumococci). The drug is therefore useful in a high proportion of bacterial diseases encountered in clinical practice and particularly in the treatment of bacterial infections of the upper and lower respiratory tract and soft tissues.

In the treatment of acute bacterial pharyngitis and tonsillitis, this antibiotic has promptly eradicated the bacteria (streptococci) and has produced a parallel prompt clinical improvement. There have been no group A beta-hemolytic streptococci resistant to this preparation. In beta-hemolytic streptococcus infections, treatment should be maintained for ten days to prevent the development of rheumatic fever or glomerulonephritis.

Erythromycin estolate has proved to be very effective in pneumococcus pneumonia and in acute bronchitis with pneumococci on culture. Bronchopneumonia and otitis media in children have responded well to its use.

The antibiotic has been used very successfully in staphylococcus infections. Good therapeutic results have been obtained in soft-tissue infections, abscesses, cellulitis, carbuncles, wound infections, and furunculosis.

In serious staphylococcus infections, erythromycin preparations should be used only in combination therapy with other antimicrobial agents. As is the case with any treatment regimen used in these severe conditions, surgical procedures should be performed when indicated, and large dosages of the antimicrobial agents should be employed. In this fashion, Ilosone has been effective in staphylococcus pneumonia, osteomyelitis, septicemia, empyema, and meningitis.

Multiple 500-mg. doses of the drug have also been useful in gonorrhea and syphilis. Since penicillin is the drug of choice for the treatment of syphilis and gonorrhea, erythromycin estolate should be employed for these infections only in patients with a history of penicillin allergy. Also, other infections due to susceptible bacteria in patients known to be hypersensitive to penicillin or other antibiotics may be considered for treatment with Ilosone.

Contraindications: Ilosone is contraindicated in patients with a known history of sensitivity to this drug and in those with preexisting liver disease or dysfunction.

Adverse Reactions: Data obtained from seven years' use of propionyl erythromycin ester and erythromycin estolate (Ilosone) indicate that hepatic dysfunction with or without clinical jaundice may occur during or following courses of therapy with the drug.

Changes in liver function tests in such cases have been indicative of intrahepatic cholestasis. The symptoms appear to be the result of a form of sensitization. The initial symptoms have developed in some cases after a few days of treatment but generally have followed one or two weeks of continuous therapy or several courses of the drug. Symptoms reappear promptly, usually within forty-eight hours, if the drug is readministered to sensitive patients. Eosinophilia was noted in peripheral blood counts. The findings readily subsided without apparent residual effects when treatment was discontinued. Recovery was delayed in one reported instance. The physician indicated in this case that either drug-induced jaundice or viral hepatitis may have been responsible for the findings.

In one clinical study involving ninety-three patients treated with the antibiotic, three cases of jaundice were observed and an additional eleven cases developed some changes in liver function tests. Three of the patients had abnormal liver function tests a second time on readministration of the drug.

Even though it is assumed that not all cases of jaundice have been reported, it seems clear that the number is small compared with the amount of drug that has been used. Reported cases have included persons in whom there had been administered other drugs known to be associated at times with hepatic side-effects and cases in which the presence of viral hepatitis or other disease may have been responsible for the findings. In some of the cases, associated gastro-intestinal symptoms simulated the colic of biliary tract disease. In other instances, clinical symptoms and results of liver function tests resembled findings in extrahepatic obstructive jaundice. It appears that the occurrence of jaundice after administration of Ilosone is infrequent, but further investigations are being made to estimate its incidence more accurately.

In those cases mentioned above in which jaundice appear be definitely related to use of the drug, laboratory findings characterized by increased direct-reacting bilirubin, elev alkaline phosphatase levels, negative or weakly positive cepl flocculation and thymol turbidity tests, elevated serum glut oxalacetic transaminase levels, peripheral eosinophilia, and mal cholecystograms.

Individual idiosyncrasy seems evident since jaundice ha been reported in other patients taking prolonged courses o medication. Patients with chronic infection have been given to 2 Gm. of the drug daily for periods of two to six months, patients with rheumatic fever have taken prophylactic dos 0.5 Gm. daily for two years without difficulty. In one grou 144 patients who received the drug daily for two years, no j dice was noted. It was of interest that members of six of t patients' families, who were not taking the drug, had epis of jaundice during the study period.

Transaminase and serum alkaline phosphatase levels determined in a group of fifty-four adults and children who 250 mg. of Ilosone daily for an average of sixteen montl rheumatic fever prophylaxis. The results were compared those of a similar group of forty-four patients who received icillin. There were no cases of jaundice in either group. Elev of SGPT and serum alkaline phosphatase levels during the co of treatment was observed in one patient treated with Ilo and in two patients treated with penicillin. Seven other pat in the group receiving Ilosone and four others in the penic group showed elevations in one of the tests at some time du administration of the drugs.

Very satisfactory therapeutic results, without toxicity, reported in 102 pediatric patients who received short-term day) courses of Ilosone in the treatment of streptococcus i tions. Results of liver function tests in these patients v comparable to those in a similar control group who had rece penicillin.

Gastro-intestinal disturbances not associated with hepati fects are observed in a small proportion of individuals as a r of a local stimulating effect of the medication on the alimen tract; however, the normal intestinal gram-negative bact flora is not appreciably altered by erythromycin drugs.

Although allergic manifestations are uncommon with the of erythromycin, there have been occasional reports of urtic skin eruptions, and, on rare occasions, anaphylaxis.

Administration and Dosage: Ilosone is administered orally.

Ilosone Pulvules®, Ilosone Liquid 125, Ilosone, 125, for Suspension, Ilosone Drops, Ilosone Chewable Tablets.

For infants and for children under twenty-five pounds of weight, the usual dosage is 5 mg. per pound every six hours children twenty-five to fifty pounds, 125 mg. every six h (Tablets Ilosone Chewable should be chewed or crushed swallowed with water.)

For adults and for children over fifty pounds, the usual do of Ilosone is 250 mg. every six hours.

For severe infections, these dosages may be doubled.

When larger doses are indicated, parenteral erythrom therapy should be considered.

In the treatment of syphilis, the recommended total dosa 20 to 30 Gm. given in divided doses for a period of ten to fif days. Close follow-up of the patient is necessary since eryt mycin drugs have not had adequate evaluation in all stage syphilis. Examinations of spinal fluid are recommended as of the follow-up therapy.

For gonorrhea, 500 mg. four times a day for four days recommended. In the treatment of gonorrhea, patients wi suspected lesion of syphilis should have a dark-field examina before receiving antibiotics, and monthly serologic tests sh be made for a period of three months.

How Supplied: Pulvules Ilosone, Capsules, N.F., 125 and 250 (equivalent to base), in bottles of 24 and 100.

Ilosone Liquid 125, Oral Suspension, U.S.P., 125 mg. (equiva to base) per 5-cc. teaspoonful, in 60-cc. and pint-size packa

Ilosone, 125, for Oral Suspension, N.F., 125 mg. (equiva to base) per 5-cc. teaspoonful, in 60 and 150-cc.-size packa

Ilosone Drops, 5 mg. (equivalent to base) per drop, in 10-cc. packages, with dropper calibrated at 25 and 50 mg.

Tablets Ilosone Chewable, N.F., 125 mg. (equivalent to ba in bottles of 50. [032

References: 1. Griffith, R. S., and Black, H. R.: Am. J. M. Sc., *247*:69, 2. Griffith, R. S., and Black, H. R.: Antibiotics & Chemother., *12*:398, 3. Hirsch, H. A., Pryles, C. V., and Finland, M.: Am. J. M. Sc., *239*:198, 1960.

Additional information available to physicians upon request.
Eli Lilly and Company, Indianapolis, Indiana 46206.

Editorial

Glimpses of Florida Medical History

He was sent there from Floyd House Hospital in April 1864 because of his special knowledge of hospital gangrene. You see, hospital gangrene was one of the major scourges at the prison hospital at Andersonville. John Crews Pelot, a boy from Nassau County, attended Jefferson Medical College and practiced medicine and surgery in Alachua County until the outbreak of the Civil War when he joined the Second Florida Cavalry as a private. His medical training was soon made known and he was transferred to the Confederate medical corps. His life at Andersonville was a grim experience as readers can easily surmise if they have read the vivid account of Andersonville Prison by McKinlay Kantor. He fared much better than the hapless Captain Henry Wirz, however, who was hanged after a mock trial to satisfy the thirst for revenge in the hearts of the Union soldiers. After the war Pelot settled in Manatee and served his community as a physician and the state as a legislator.

Recently his granddaughter has supplied your Archives Committee with much interesting information and a picture of this remarkable man. If you know of similar information or material about physicians in the practice of medicine in your area, won't you get it together and send it to the Florida Medical Association? We are working toward a history of the development of medicine in Florida and will be most grateful for any help you can give us.

William M. Straight, M.D., Chairman
Committee on Archives
Miami



After the picnic even Gramps Was a victim of intestinal cramps

Parepectolin for quick relief of acute diarrhea
...soothes colicky pain with paregoric*
...consolidates fluid stools with pectin
...adsorbs irritants with kaolin, and protects intestinal mucosa

In elderly patients it is particularly important to stop the diarrhea fast. Parepectolin helps you control diarrhea promptly and gain the patient's confidence until etiology has been determined.

Parepectolin®

Each fluid ounce of creamy white suspension contains:
*Paregoric (equivalent) (1.0 dram) 3.7 ml.
Contains opium (¼ grain) 15 mg. per fluid ounce.
warning: may be habit forming
Pectin (2½ grains) 162 mg.
Kaolin (specially purified) (85 grains) 5.5 Gm.
(alcohol 0.69%)
Usual Adult Dose: One or two tablespoonfuls three times daily.

ROER
WILLIAM H. RORER, INC.
Fort Washington, Pa.

In peptic ulcer... antacid therapy with a new benefit



CONTAINS A BALANCED COMBINATION OF THE MOST WIDELY USED ANTACIDS— FOR RAPID NEUTRALIZATION. PLUS SIMETHICONE— TO CONTROL THE FACTOR WHICH ANTACIDS ALONE CANNOT INFLUENCE.

Mylanta®

- In Mylanta, aluminum and magnesium hydroxides are balanced to minimize the chance of constipation or laxation and still achieve rapid acid neutralization and pain relief.
- The positive action of simethicone helps relieve the painful gas symptoms which often accompany the peptic ulcer syndrome.
- The nonfatiguing flavor and smooth, nongritty consistency of tablets and liquid encourage continued patient cooperation during long-term therapy.

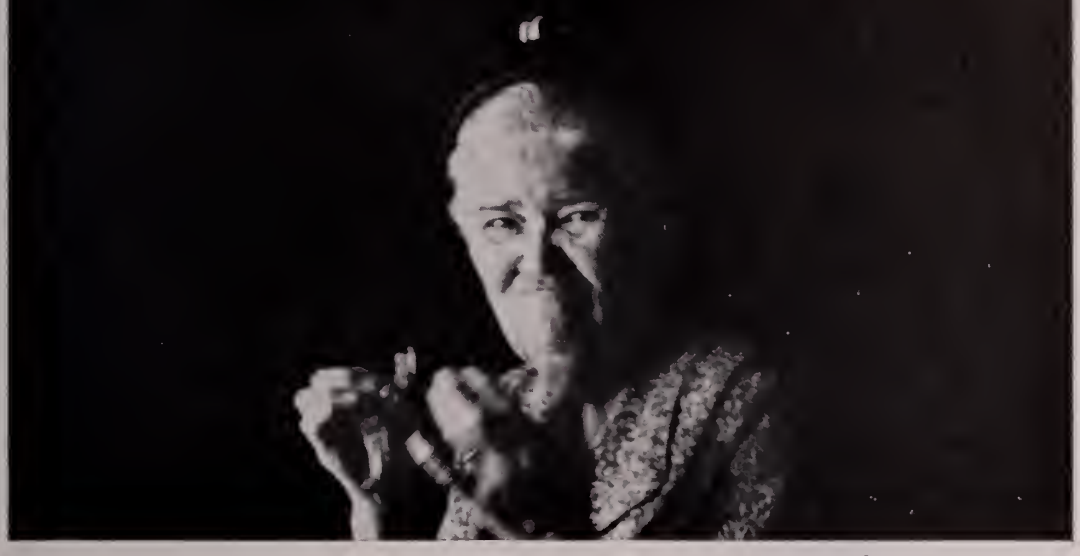
Composition: Each Mylanta chewable tablet or teaspoonful (5 ml.) of liquid contains: magnesium hydroxide, 200 mg.; aluminum hydroxide, dried gel, 200 mg.; simethicone, 20 mg. **Dosage:** one or two tablets, well chewed or allowed to dissolve in the mouth, or one or two teaspoonfuls of liquid to be taken between meals and at bedtime.

The Stuart Company, Pasadena, California
Division of Atlas Chemical Industries, Inc.

Stuart

IRON DEFICIENCY

ANEMIA



Imferon®

(iron dextran injection)

There's as much iron . . . 250 mg. . . . in a 5 cc. ampul of Imferon (iron dextran injection) as in a pint of whole blood. When iron deficient patients are intolerant of oral iron . . . or orally administered iron proves ineffective or impractical . . . or if the patient cannot be relied upon to take oral iron as prescribed, Imferon (iron dextran injection) dependably increases hemoglobin and rapidly replenishes iron reserves. Precise dosage is easily calculated.

LAKESIDE

IN BRIEF: ACTION AND USES: A single dose of Imferon (iron dextran injection) will measurably begin to raise hemoglobin and a complete course of therapy will effectively rebuild iron reserves. The drug is indicated only for specifically-diagnosed cases of iron deficiency anemia and then only when oral administration of iron is ineffective or impractical. Such iron deficiency may include: patients in the last trimester of pregnancy; patients with gastrointestinal disease or those recovering from gastrointestinal surgery; patients with chronic bleeding with continual and extensive iron losses not rapidly replenishable with oral iron; patients intolerant of blood transfusion as a source of iron; infants with hypochromic anemia; patients who cannot be relied upon to take oral iron.

COMPOSITION: Imferon (iron dextran injection) is a well-tolerated solution of iron dextran complex providing an equivalent of 50 mg. in each cc. The solution contains 0.9% sodium chloride and has a pH of 5.2-6.0. The 10 cc. vial contains 0.5% phenol as a preservative.

ADMINISTRATION AND DOSAGE: Dosage, based upon body weight and Gm. Hb/100 cc. of blood, ranges from 0.5 cc. in infants to 5.0 cc. in adults, daily, every other day, or weekly. Initial test doses are advisable. The total iron requirement for the individual patient is readily obtainable from the dosage chart in the package insert. Deep intramuscular injection in the upper outer quadrant of the buttock, using a Z-track technique, (with displacement of the skin laterally prior to injection), insures absorption and will help avoid staining of the skin. A 2-inch needle is recommended for the adult of average size.

SIDE EFFECTS: Local and systemic side effects are few. Staining of the skin may occur. Excessive dosage, beyond the calculated need, may cause hemosiderosis. Although allergic or anaphylactoid reactions are not common, occasional severe reactions have been observed, including three fatal reactions which may have been due to Imferon (iron dextran injection). Urticaria, arthralgia, lymphadenopathy, nausea, headache and fever have occasionally been reported.

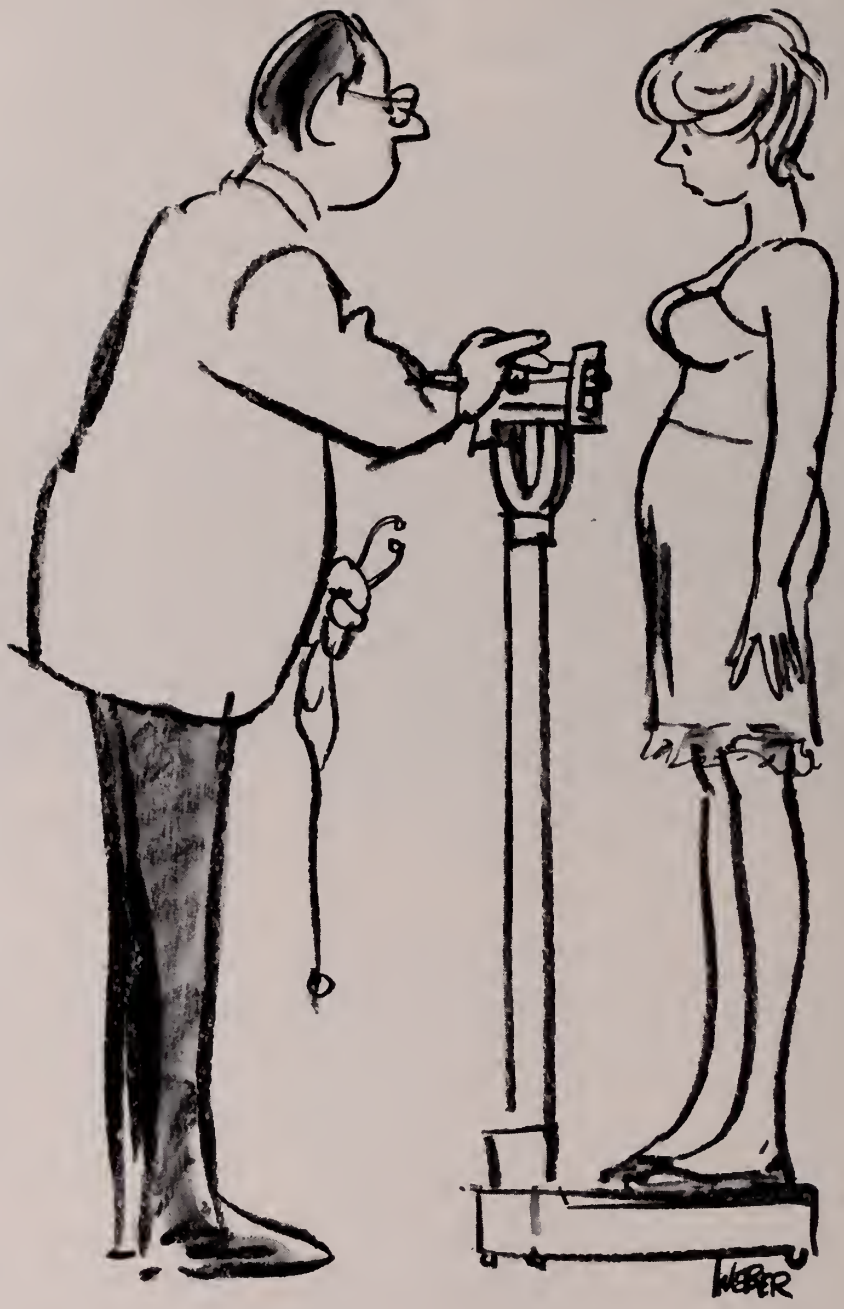
PRECAUTIONS: If sensitivity to test doses is manifested, the drug should not be given. Imferon (iron dextran injection) must be administered by deep intramuscular injection only. Inject only in the upper outer quadrant of the buttock, not in the arm or other exposed area.

CONTRAINDICATIONS: Imferon (iron dextran injection) is contraindicated in patients sensitive to iron dextran complex. Since its use is intended for the treatment of iron deficiency anemia only it is contraindicated in other anemias.

CARCINOGENICITY POTENTIAL: Using relatively massive doses, Imferon (iron dextran injection) has been shown to produce sarcoma in rats, mice and rabbits and possibly in hamsters, but not in guinea pigs. The risk of carcinogenesis, if any in man, following recommended therapy with Imferon (iron dextran injection) appears to be extremely small.

SUPPLIED: 2 cc. ampuls, boxes of 10, 5 cc. ampuls, boxes of 4; 10 cc. multiple dose vials.

LAKESIDE LABORATORIES, INC., Milwaukee, Wisconsin 53201



"You're up ten pounds since your last physical. We're going to have to do something about that."

Get them while they're easily reversible.

Obesity doesn't happen suddenly. This insidious process has its beginning—and the chances of reversing it are better—during the *first 10 to 15 pounds of weight gain.* When a new dietary pattern must be established, consider the adjunctive use of BAMADEX SEQUELS. Combining the proven *anorexigenic* action of d-amphetamine with the *tranquilizing* effect of meprobamate, BAMADEX SEQUELS controls appetite throughout the day, usually with a single capsule daily.

Contraindications: Dextro-amphetamine sulfate: In hyperexcitability and in agitated prepsychotic states. Previous allergic or idiosyncratic reactions to meprobamate.
Precautions: Use with caution in patients hypersensitive to sympathomimetic compounds, who have coronary or cardiovascular disease, or are severely hypertensive.

Dextro-amphetamine sulfate: Excessive use by unstable individuals may result in psychological dependence.

Meprobamate: Careful supervision of dose and amounts prescribed is advised, especially for patients with known propensity for taking excessive quantities of drugs. Excessive and prolonged use in susceptible persons, e.g. alcoholics, former addicts, and other severe psychoneurotics, has been reported to result in dependence on the drug. Where excessive dosage has continued for weeks or months, reduce dosage gradually. Sudden withdrawal may precipitate recurrence of preexisting symptoms such as anxiety, anorexia, or insomnia; or withdrawal reactions such as vomiting, ataxia, tremors, muscle twitching and, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, reduce dosage and avoid operation of motor vehicles, machinery or other activity requiring alertness. Effects of excessive alcohol consumption may be increased by meprobamate. Appropriate caution is recommended with patients prone to excessive drinking. In patients prone to both petit and grand mal epilepsy meprobamate may precipitate grand mal attacks. Prescribe cautiously and in small quantities to patients with suicidal tendencies.
Side Effects: Overstimulation of the central nervous system, jitteriness and insomnia or drowsiness. Dextro-amphetamine sulfate: Insomnia, excitability, and increased motor activity are common and ordinarily mild side effects. Confusion, anxiety, aggressiveness, increased libido, and hallucinations have also been observed, especially in mentally ill patients. Rebound fatigue and depression may follow central stimulation. Other effects may include dry mouth, anorexia, nausea, vomiting, diarrhea, and increased cardiovascular reactivity.

Meprobamate: Drowsiness may occur and can be associated with ataxia; the symptom can usually be controlled by decreasing the dose, or by concomitant administration of central stimulants. Allergic or idiosyncratic reactions: maculopapular rash, acute nonthrombocytopenic purpura with petechiae, ecchymoses, peripheral edema and fever, transient leukopenia. A case of fatal bullous dermatitis, following administration of meprobamate and prednisolone, has been reported. Hypersensitivity has produced fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, stomatitis, proctitis (1 case), anaphylaxis, agranulocytosis and thrombocytopenic purpura, and a fatal instance of aplastic anemia, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity, usually after excessive dosage. Impairment of visual accommodation. Massive overdosage may produce drowsiness, lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

Bamadex® Sequels®

Dextro-amphetamine sulfate (15 mg.) with Meprobamate (300 mg.) Sustained Release Capsules

Lederle

LEDERLE LABORATORIES
A Division of American Cyanamid Company
Pearl River, New York

466-7

Sick, and worried sick



Professionally posed



Anxiety and tension stemming from organic illness may undermine your patient's cooperation and possibly retard success of primary therapy.

If his emotional symptoms persist in the face of your counsel and reassurance, you may want to consider adjunctive use of SERAX (oxazepam). It is indicated in anxiety, tension, agitation, irritability, and anxiety associated with depression. May be used in a broad range of patients, usually with considerable dosage flexibility.

When prescribing, carefully observe dosage recommendations and appropriate precautions, especially as pertaining to the elderly and when complications could ensue from a fall in blood pressure. (See Wyeth literature or PDR as well as "IN BRIEF" below.)

IN BRIEF.

Contraindications: History of previous hypersensitivity to oxazepam. Oxazepam is not indicated in psychoses.

Precautions: Hypotensive reactions are rare, but use with caution where complications could ensue from a fall in blood pressure, especially in the elderly. Withdrawal symptoms upon discontinuation have been noted in some patients exhibiting drug dependence through chronic overdose. Carefully supervise dose and amounts prescribed, especially for patients prone to overdose; excessive, prolonged use in susceptible patients (alcoholics, ex-addicts, etc.) may result in dependence or habituation. Reduce dosage gradually after prolonged excessive dosage to avoid possible epileptiform seizures. Withdrawal symptoms following abrupt discontinuance are similar to those seen with barbiturates. Caution patients against driving or operating machinery until absence of drowsiness or dizziness is ascertained. Warn patients of possible reduction in alcohol tolerance. Safety for use in pregnancy has not been established.

Not indicated in children under 6 years; absolute dosage for 6- to 12-year-olds not established.

Side Effects: Therapy-interrupting side effects are rare. Transient mild drowsiness is common initially; if persistent, reduce dosage. Dizziness, vertigo and headache have also occurred infrequently; syncope, rarely. Mild paradoxical reactions (excitement, stimulation of affect) are reported in psychiatric patients. Minor diffuse rashes (morbilliform, urticarial and maculopapular) are rare. Nausea, lethargy, edema, slurred speech, tremor and altered libido are rare and generally controllable by dosage reduction. Although rare, leucopenia and hepatic dysfunction including jaundice have been reported during therapy. Periodic blood counts and liver function tests are advised. Ataxia, reported rarely, does not appear related to dose or age. These side reactions, noted with related compounds, are not yet reported: paradoxical excitation with severe rage reactions, hallucinations, menstrual irregularities, change in EEG pattern, blood dyscrasias (including agranulocytosis), blurred vision, diplopia, incontinence, stupor, disorientation, fever and euphoria.

Availability: Capsules of 10,15 and 30 mg. oxazepam.

To help you relieve anxiety and tension

Serax® (oxazepam)

Wyeth® SERVICE TO MEDICINE

Wyeth Laboratories
Philadelphia, Pa.

Soyalac

SOLVES THE PROBLEM

for the infant who requires a milk-free diet!



- Soyalac satisfies! Baby is happy, mother is grateful, doctor is gratified.
- The nut-like taste is pleasing. Infants readily accept this hypoallergenic formula that is completely fibre-free. An exclusive process results in a consistency much like milk.
- Soyalac is strikingly similar to mother's milk in composition and ease of assimilation. Clinical data furnish evidence of Soyalac's value in promoting normal growth and development.
- Excellent for regular infant feeding, too—and for growing children and adults.

Soyalac

Free Booklet and Samples

A request on your professional letterhead or prescription form will bring to you complete information and a supply of samples.

a product of

LOMA LINDA FOODS

MEDICAL PRODUCTS DIVISION

RIVERSIDE, CALIFORNIA

Mount Vernon, Ohio, U. S. A.

There are 59,700* undetected diabetics in Florida

Most of these are probably among patients over 40; the overweight; relatives of diabetics, and mothers of large babies. By the time polyphagia, polyuria, polydipsia, pruritus or other overt symptoms of diabetes appear, damage may have been done that could have been minimized. DEXTROSTIX® gives you a reliable blood-glucose estimate in 60 seconds.

Why Wait?



*Based on Statistical Report, U.S. Dept. Commerce, ed. 86, and Fisher, G. F., and Vavra, H. M.: Pub. Health Rep. 80:961 (Nov.) 1965.

Note: DEXTROSTIX is not meant to replace the more precise analytical laboratory procedures such as needed in glucose tolerance testing.

AMES COMPANY, Division Miles Laboratories, Inc., Elkhart, Indiana 46514 428R67

Ames



when he just can't sleep

Tuinal

One-Half Sodium Amobarbital and
One-Half Sodium Secobarbital
supplied in ¾, 1½, and 3-grain Pulvules



Tuinal helps wakeful patients fall asleep fast, stay asleep all night.

Indications: Tuinal is indicated for prompt and moderately long-acting hypnosis. It is not suitable for continuous daytime sedation.

Contraindications: Barbiturates should not be administered to anyone with a history of porphyria, nor should they be given in the presence of uncontrolled pain, because excitement may result.

Warning: May be habit-forming.

Precautions: Tuinal should be used cautiously in patients with decreased liver function, since prolongation of effect may occur.

Adverse Reactions: Idiosyncrasy, such as excitement, hangover, or pain, may appear. Hypersensitivity reactions occur in some patients, especially in those with asthma, urticaria, or angioneurotic edema.

Overdosage: C.N.S. depression. Symptoms—Depression of respiration and of superficial and deep reflexes, slight constriction of the pupils (in severe poisoning, dilation), decreased urine formation, lowered body temperature, coma. Treatment—Symptomatic and supportive (gastric lavage; intravenous fluids; maintenance of blood pressure, body temperature, and adequate respiration). Dialysis may speed removal of barbiturates from body fluids.



Dosage: 50-200 mg. (¾-3 grains) at bedtime.

[031767]

Additional information available to physicians upon request.
Eli Lilly and Company • Indianapolis, Indiana 46206

700955

Lilly

DIURESIS



MERCUHYDRIN®
(meralluride injection)

Twenty years ago the publication of "A System for the Routine Treatment of the Failing Heart"[1] established a schedule of diuretic therapy as a primary factor in the treatment of acute congestive failure. With emphasis upon daily injections of Mercuhydrin (meralluride injection) until dry weight was obtained, Gold, et al. achieved a 40% increase in improvement, in ⅓ the time, over other methods then current. Today, most medical texts continue to recommend parenteral mercurials in acute congestive failure when prompt diuresis is indicated.

Recently Modell[2] has stated: "The mercurial diuretics are the injectable diuretics of choice since they are the most potent as well as the most dependable. Their toxicity is not an important consideration either by comparison with other potent diuretics or in relation to the seriousness of the conditions in which they provide such excellent relief."

LAKESIDE

IN BRIEF

Mercuhydrin is indicated in edema of cardiac or hepatic origin and in the nephrotic syndrome; it is contraindicated in acute nephritis and in anuric or oliguric states. *The usual adult dose is one to two cc. daily or every other day until "dry weight" is obtained.* Sensitivity is rare but small initial doses are advised to minimize potential reactions; vertigo, fever, and rash have occurred. Overdosage may produce electrolyte depletion, muscle cramps, and G. I. reactions. Supplied: 1 cc. and 2 cc. ampuls in boxes of 12, 25 and 100; 10 cc. rubber capped, multiple-dose vials (intramuscular or subcutaneous use only) in boxes of 6 and 100.

1. Gold, Harry, *et al.: A System for the Routine Treatment of the Failing Heart,* The American Journal of Medicine, Vol. III, No. 6:665-692 (Dec.) 1956.

2. Modell, Walter: *Drugs of Choice 1966-1967,* p. 97, 1966.

LAKESIDE LABORATORIES, INC., Milwaukee, Wisconsin 53201

NEWS

Fishing Tournament Winner Announced

Dr. Paul E. Coury of Bartow was the winner in the FMA first annual Big Game Fishing Tournament held during and after the FMA Annual Meeting, May 11-14, Bal Harbour.

Dr. Coury won both categories, longest fish and heaviest fish, with a 42 lb. 7'4" sailfish. Runner-up was Dr. Haskell H. Bass, Bradenton, with a 26.5 lb. 6'5" sailfish.

Dr. Coury will be awarded his trophies at a meeting of the Polk County Medical Association. Four trophies are involved, one large and one small for each category. The large trophies are to be kept on permanent display by the Dade County Medical Association. The small trophies are kept permanently by the respective winner or winners and are replaced each year.

Approximately 50 physicians participated in the tournament. Trophies were donated by the Dade County Medical Association and engraving was courtesy of the FMA. Chairman of the Fishing Committee was Dr. Hobart T. Feldman, Miami, who also captained the boat from which the winning fish was caught.

'Pursuit of Power' Now Available

A recently published book by Marjorie Shearon, Ph.D., editor of the newsletter Challenge to Socialism and former consultant to Sen. Robert A. Taft, purports the explanation of how Medicare came about.

The book, "Wilbur J. Cohen, The Pursuit of Power," is available through the Shearon Legislative Service, 8801 Jones Mill Road, Chevy Chase, Maryland 20015.

FMA Member Honored

Dr. Richard T. Farrior, Tampa, otolaryngologist and FMA member, was elected president of the American Academy of Facial Plastic and Reconstructive Surgery at the close of the group's three day scientific and business meeting May 25-27 in Montreal, Canada.

Medical Exam Board Elects Dr. Palmer Executive Director

Dr. George S. Palmer, Tallahassee pediatrician, was recently elected executive director of the State Board of Medical Examiners, succeeding the late Dr. Homer L. Pearson of Miami.

The board in a regular semi-annual meeting also elected as president Dr. Madison R. Pope, Plant City; vice president, Dr. Carl C. Mendoza, Jacksonville, and secretary-treasurer, Dr. Scheffel H. Wright, Miami.

Dr. Palmer, immediate past president of the Florida Medical Association, was a member of the medical examining board for eight years and served as its president in 1958-59. A native of Tallahassee, Dr. Palmer has practiced medicine there since 1948 following graduation from Johns Hopkins University School of Medicine and post-graduate training in Baltimore. He has held a variety of medical offices on state and local levels during the past two decades.

Poisonous Plants Color Wall Charts Now Available to Aid Physicians

"Plants Poisonous to People" wall charts, with large color photographs and definitive captions, are now available to aid physicians, poison control centers, emergency rooms and others interested in poisonous plants.

The two 23 x 35 inch charts, arranged by Julia Morton, director of the Morton Collectanea of the University of Miami, include color photographs and captions on 42 plants poisonous to people.

Several of Mrs. Morton's color photos appeared in a scientific article by Ray O. Edwards, M.D., in the December 1965 issue of the Journal.

Charts number one, Causes of Internal Poisoning, and number two, Causes of Skin and Respiratory Irritation, are available through Hurricane House Publishers, 14301 S.W. 87th Avenue, Miami 33158.

INFLAMMATION:
A cellular fight for life

A SYNTEX REPORT based on recently developed hypotheses about topical corticosteroids, including the cellular theories of inflammation by Thomas F. Dougherty, Ph.D., University of Utah.

You are looking at a fibroblast fighting for life. This cell—one of the most common found in connective tissue—has literally been poisoned by cytotoxins released from other cells that have ruptured. Soon, if the abnormal activity of this fibroblast does not cease, it, too, will rupture and die—one more casualty in the inflammatory wave of destruction precipitated by injury.

Until a short time ago no one had ever witnessed such a scene at the cellular level. Now, through advanced cinemicrographic techniques, it is possible to view and photograph the inflammatory process as produced experimentally in living animal tissue. This method permits new insight into the mechanism of inflammation and the role of corticosteroids in therapeutic management. Equally important, these techniques shed new light on factors that may make one corticosteroid more effective than another—factors that can be correlated with other chemical, biologic, and clinical parameters.

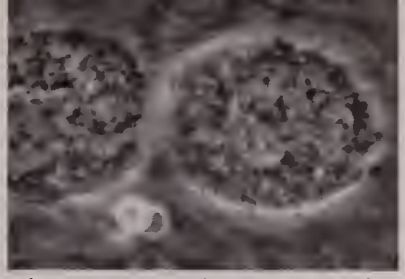


Visual evidence of how corticosteroids influence the inflammatory reaction

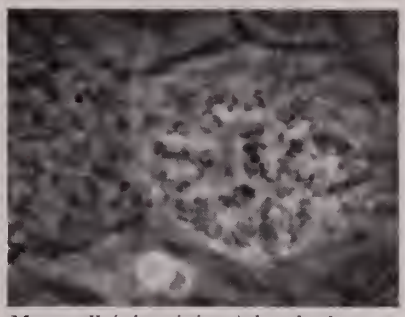
Working with phase-contrast cinemicrography on living animal tissue, Doctors Thomas F. Dougherty and David Berliner of the University of Utah College of Medicine have actually filmed cellular events that occur during the inflammatory reaction. This remarkable study* and additional work by these investigators, as well as by others, have established a new theoretical biologic basis for the antiinflammatory effect of the corticosteroids. (It must be noted that other theories, such as the lysosome or so-called "suicide bag" theory, have been postulated, although it is quite likely that there are more similarities than differences among the various theoretical models.)

The inflammatory wave of destruction

In this investigation an injurious injection of gelatin is used to set off an inflammatory reaction in living mouse tissue. What follows is a wave of destructive cellular activity that comprises the inflammatory response to injury. Mast cells (which contain heparin, serotonin and histamine) take up water, swell and rupture, releasing their contents, which are toxic outside the mast cell wall. These toxins, in turn, cause disintegration of other cells (such as fibroblasts) and the release of additional toxic material. Capillaries, too, take up water and leak unformed blood elements, causing edema. And polymorphonuclears, lymphocytes and perithelial cells invade the inflamed site. As a result of all these changes, the cellular environment reaches a state of turmoil.



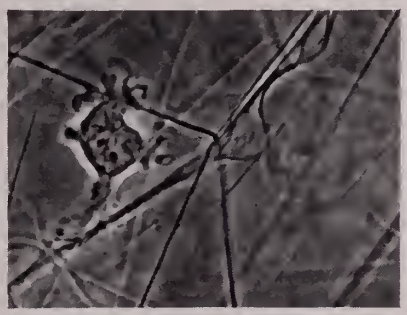
Phase-contrast microscopy showing mast cell before injury.



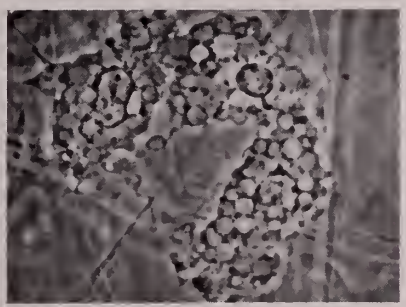
Mast cell (after injury) has broken up and released cytotoxins.

How corticosteroids change the picture

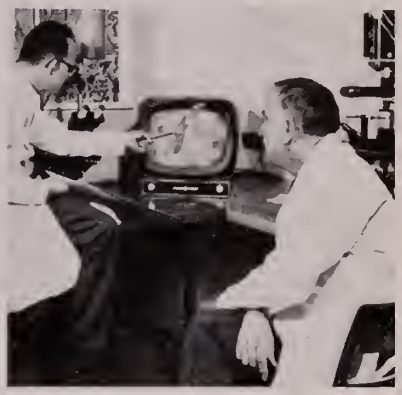
Corticosteroids appear to virtually stop the abnormal cellular activity that constitutes the inflammatory reaction. This permits the body's natural resources to clear up the inflamed area and repair the damaged tissue. This interpretation is supported by the fact that when the injurious gelatin solution is injected simultaneously with a corticosteroid —Synalar (fluocinolone acetonide)— the inflammatory pattern simply does not develop.



Fibroblast in high state of activity, much distorted.



Mast cells showing effects of corticosteroid action: cells are normal in size, shape and activity.



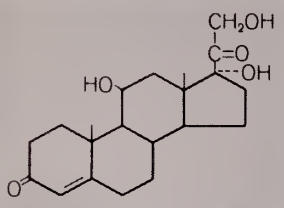
In summarizing his study Doctor Dougherty states: "...we also feel this work may explain why one corticosteroid helps a patient more rapidly and effectively than another. If it does, it is because one corticosteroid is the fastest, most effective inhibitor of the series of inflammatory events at the tissue level."

**A New View of Corticosteroid Action in Inflammatory Dermatoses,* a film based on this study, is now available from your Syntex representative.

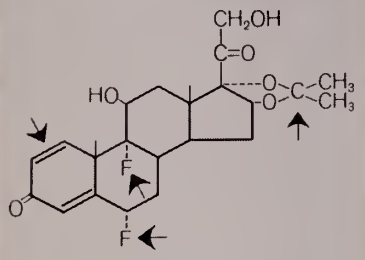
See last page for contraindications, precautions, side effects and dosage.

How advances in chemical design have achieved greater steroid potency

The chemical modification of corticosteroid molecules from the advent of hydrocortisone to the development of Synalar (fluocinolone acetonide) is a prime example of how biochemists can "design" to increase therapeutic activity and minimize undesirable side actions. Below, for example, we see the important changes that were made in reference to the hydrocortisone molecule to produce fluocinolone acetonide, one of the most active of all topical corticosteroids. As a result, a 0.01% preparation of Synalar (fluocinolone acetonide) has been reported to do the work of a 1% hydrocortisone product containing 100 times more cortiscosteroid. And it can often do it more effectively.



Hydrocortisone

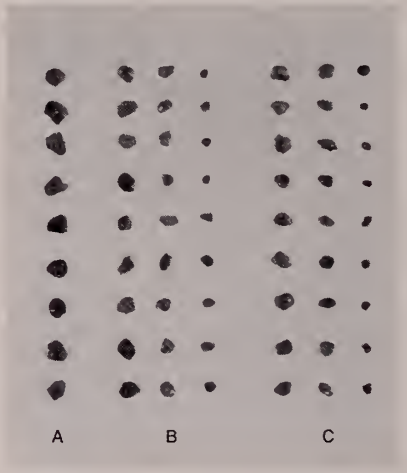


Fluocinolone Acetonide (Synalar)

- *a double bond between carbons 1 and 2*
- *fluorine substitutions at* both *the 6-α, and the 9-α positions*
- *the addition of the acetonide at the 16-α, 17-α positions, thus providing one of the most potent topical corticosteroids available.*

How bioassay tests are used to "predict" therapeutic potential

Biologic assays are another tool used by researchers to help establish the relative activity of corticosteroids. To date no single method of assaying corticosteroid activity has emerged as the ideal "yardstick" for predicting therapeutic potential. Taken together, however, these methods have proved useful. When such tests are run on various corticosteroids, a definite order of corticosteroid activity becomes evident. Compounds with the highest order of activity may be expected to merit clinical trial to establish their high therapeutic potential. When assayed by these methods, fluocinolone acetonide (Synalar) emerges as one of the most active topical corticosteroids, milligram for milligram, available for clinical application today.



THE THYMUS INVOLUTION ASSAY[1-4] is run on adrenalectomized rats. The sizes of the glands are measured, and the degree of involution caused by the steroid is determined as an indication of its potency. In the above photo, the comparative involution of thymus glands achieved with hydrocortisone and Synalar (fluocinolone acetonide) is shown. Untreated controls (A) show normal size. Group B – injected with 1, 2 and 4 mg. of hydrocortisone – show progressively smaller thymuses as does Group C – injected with fluocinolone acetonide – but with only 1/500th the dose of hydrocortisone.



THE ANTIGRANULOMA ASSAY[1-4] also utilizes adrenalectomized rats. Granulomas are induced by subcutaneous implantation of cotton pellets on either side of the thorax. The degree of granuloma inhibition achieved by a steroid reflects its potency. The above photo shows the inhibition of granuloma formation achieved with hydrocortisone and Synalar (fluocinolone acetonide). Untreated controls (A) show large, red granulomas adhering to the pellets. Group B, receiving hydrocortisone and Group C, receiving fluocinolone acetonide, show little, if any, granuloma formation. Fluocinolone acetonide produced the same effect as hydrocortisone with only 1/500th the dose. This assay, as well as the thymus involution assay, measures systemic rather than topical corticosteroid activity. Nevertheless, results by these methods correlate well with other assays and with the milligram potencies of topical steroids in current clinical use.

Worldwide clinical experience confirms the predictable therapeutic potential of Synalar

It is particularly gratifying that the promise of the advanced chemical design and high order of bioassay activity of Synalar (fluocinolone acetonide) has been confirmed by widespread therapeutic application. Indeed, the impressive clinical response rate of Synalar has been documented in no fewer than 232 papers from 22 countries.

Representative Clinical Results with Synalar*

Efficacy Documented in over 4,000 Patients

Condition	Number of Publications	Number of Patients	Significant Improvement†
Contact Dermatitis	27	750	713
Eczematous Dermatitis	21	472	409
Seborrheic Dermatitis	18	442	426
Atopic Dermatitis	24	460	426
Psoriasis	36	1,699	1,510
Neurodermatitis	18	351	324
Total	144	4,174	3,808

*Complete bibliography on request.

†Expressed by the authors as excellent, very good, good, complete remission of inflammation, etc.

PRESCRIBING INFORMATION

For initiation of therapy: Cream 0.025%, 5 and 15 Gm. tubes, 425 Gm. jars; *for emollient effect:* Ointment 0.025%, 15 Gm. tubes; *for maintenance therapy:* Cream 0.01%, 15 and 45 Gm. tubes, 120 Gm. jars; *for intertriginous or hairy sites:* Solution 0.01%, 20 cc. and 60 cc. plastic squeeze bottles; *for infected inflammatory dermatoses:* Neo-Synalar® Cream (0.025% fluocinolone acetonide, neomycin sulfate, equivalent to 0.35% neomycin base), 5 and 15 Gm. tubes. CONTRAINDICATIONS: Tuberculous, fungal, and most viral lesions of the skin, (including herpes simplex, vaccinia, and varicella). Not for ophthalmic use. Contraindicated in individuals with a history of hypersensitivity to any of the components. PRECAUTIONS: Synalar preparations are virtually nonsensitizing and nonirritating. However, the solution may produce burning or stinging when applied to denuded or fissured areas. In some patients with dry lesions, the solution may increase dryness, scaling or itching. While topical steroids have not been reported to have an adverse effect on pregnancy, the safety of their use on pregnant females has not absolutely been established. Therefore, they should not be used extensively on pregnant patients, in large amounts, or for prolonged periods of time. Prolonged use of any antibiotic may result in overgrowth of nonsusceptible organisms; if this occurs, appropriate therapy should be instituted. When severe local infection or systemic infection exists, the use of systemic antibiotics should be considered, based on susceptibility testing. SIDE EFFECTS: Side effects are not ordinarily encountered with topically applied corticosteroids. As with all drugs, however, a few patients may react unfavorably to Synalar under certain conditions. The neomycin in Neo-Synalar Cream rarely produces allergic reactions.

REFERENCES: 1. Lerner, L. J., Bianchi, A., Turkheimer, A. R., Singer, F. M., and Borman, A.: Anti-inflammatory steroids: potency, duration and modification of activities. Ann NY Acad Sci 116:1071 (Aug. 27) 1964. 2. Idem: Comparison of anti-granuloma, thymolytic and glucocorticoid activities of anti-inflammatory steroids. Proc Soc Exp Biol Med 116:385 (June) 1964. 3. Ringler, A.: Activities of adrenocorticosteroids in experimental animals and man, in Dorfman, R. I.: Methods of hormone research, New York, Academic Press, 1964. vol. III. pp. 234-280. 4. Gubersky, V. R.: To be published.

fluocinolone acetonide—an original steroid from

SYNTEX LABORATORIES INC., PALO ALTO, CALIF.

For inflammatory dermatoses... by any measure a topical corticosteroid of choice

Synalar® (fluocinolone acetonide)

Milligram for milligram one of the most active topical corticosteroids available

Rapid and predictable in antiinflammatory and antipruritic activity

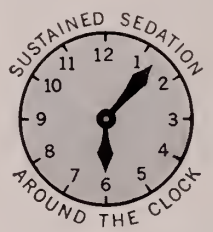
Results often comparable to those of systemic corticosteroids with fewer hazards

removes the mental blur

that clouds vision

SOLFOTON®

Each tablet or capsule contains
PHENOBARBITAL.....16 mg.
(Warning: may be habit forming)
BENSULFOID® (See P D R).....65 mg.
Precaution: same as 16 mg. of phenobarbital



Constructive Therapy

A Solfoton tablet or capsule at 6 hour intervals maintains sedation at the threshold of calmness, sustaining a mental climate for purposeful living.

Literature and clinical samples sent upon request.

FEDERAL LAW PROHIBITS DISPENSING WITHOUT PRESCRIPTION

AVAILABLE

Solfoton *(yellow, uncoated tablets "P")*
100s, 500s, 5000s

Solfoton Capsules *(yellow and brown)*
100s, 500s, 1000s

Solfoton S/C *(sugar-coated beige tablets)*
100s, 500s, 4000s

WM. P. POYTHRESS & CO., INC.
RICHMOND, VIRGINIA 23217
Manufacturers of ethical pharmaceuticals since 1856



Letters

Dear Editor:

As you may have heard, there are plans in progress regarding the establishment of a Florida Medical Association sponsored medical museum at the old hospital building recently restored in St. Augustine. Through the efforts of Dr. William Straight of the Archives Committee, much study and planning have gone into the investigation of this building for future development along the lines of a progressive type museum depicting the various phases of medical history in Florida. Since St. Augustine was under the control of four governments in the past—Spanish, French, English and finally the Confederacy—you can see there will be much of history that can be displayed in the building.

At the present time, it is believed that the historical facts should include a progression dating back as far as the recorded historical facts will allow. After meeting with members of the Restoration Commission, Mr. Earle Newton, Mr. Brewer, Dr. Calkins and Dr. Straight, we thought that for the ensuing year we would try to outfit a doctor's office on the ground floor and accumulate relics from the physicians throughout Florida and put them in glass cases on the second floor, the walls of which would contain sectional murals depicting scenes such as those selected by Dr. Straight; examples of these are a Timuquan witch doctor treating a patient in the great house of the Huguenot colony at Fort Caroline, East of Jacksonville, 1564, and Ponce de Leon injured by an Indian arrow and being treated by a barber surgeon in a pine thicket. The latter has been documented in the August 1966 issue of the Journal. Another is the lean-to hospital in St. Augustine in 1597, the first hospital in the United States as we now know it. Another would be an English

military hospital in St. Augustine about the 1700's with a barber surgeon operating on an injured man; a scene depicting Governor Andrew Jackson issuing a proclamation and ordinance for the preservation of health in the 1818-1821 period and standing at his right hand is Dr. James Crane Brenaugh, the first physician admitted to practice in the state of Florida and Assistant Surgeon-General of the U. S. Army. These are some of the actual types of scenes that will be depicted by murals and eventually by dioramas. These murals will be removable and can be used on display about the state and the slot from which they are removed could possibly retain a diorama.

The approximate cost of the work as outlined at the present time, which would be an apothecary shop, a surgery, medical wards, possibly one or two scenes as depicted above with the life size mannequins plus a series of mural placards on the second floor with the glass cases containing the relics, would come to between $15,000 and $20,000. This need not be done all at one time, but gradually throughout the coming years and possibly with the help of FMA members and with the consideration of drug houses sponsoring dioramas. This wonderful continuing reminder of our medical heritage in Florida, with its tremendously long history, can be offered not only to the people of Florida but to the many peoples of the world who daily come through St. Augustine.

I trust that all of the physicians in Florida will be as interested in the medical museum as we are here in St. Augustine. We welcome a visit at any time from physicians and would be glad to discuss with them any of the plans for the future. We are also interested in the possibility of the physicians of the state contributing a small amount, $5 to $10 a year, for the upkeep and perpetuation of this project.

I hope that many of the members of the Association visited the booth describing these plans at the FMA Annual Meeting in Miami.

James J. DeVito, M.D.
St. Augustine

mudrane®

for

- EMPHYSEMA
- ASTHMA
- CHRONIC BRONCHITIS
- BRONCHIECTASIS

The fast-disintegrating uncoated tablet gives relief in 15 minutes

Each tablet contains:

Potassium Iodide	195 mg.
Aminophylline	130 mg.
Phenobarbital, Caution: May be habit forming...	21 mg.
Ephedrine HCl	16 mg.

FEDERAL LAW PROHIBITS
DISPENSING WITHOUT PRESCRIPTION

Precautions: Usual for aminophylline-ephedrine-phenobarbital. Iodides may cause nausea, long use may cause goiter. Discontinue if symptoms of iodism develop.

Iodide contraindications: tuberculosis, pregnancy.

DOSAGE

One tablet, with full glass of water, 3 or 4 times daily.

Dispensed in bottles of 100 and 1000 tablets.

MUDRANE GG—Formula, dosage and package identical to Mudrane—*except*—100 mg. glyceryl guaiacolate replaces the potassium iodide. The value of Mudrane cannot be enjoyed by a small group in which K.I. is contraindicated. Mudrane GG is prepared for this group.

MUDRANE GG ELIXIR—Four 5 cc teaspoonfuls is equivalent to one Mudrane GG tablet. Dosage adjusted to age and weight of child. Mudrane GG Elixir is for pediatric patients and those who think they cannot swallow tablets. Dispensed in pint and half gallon bottles.

WM. P. POYTHRESS & CO., INC.
RICHMOND, VIRGINIA 23217
Manufacturers of ethical pharmaceuticals since 1856


1 PINT (473 cc.)
M-87
SUSPENSION
CO-PYRONIL
PYRROBUTAMINE COMPOUND
100 No. 336
PULVULES
CO-PYRONIL
PYRROBUTAMINE COMPOUND
000
No. 347
PULVULES
CO-PYRONIL
PYRROBUTAMINE COMPOUND
Pediatric
for
quick relief
that lasts
and lasts
Co-Pyronil®
Pyrrobutamine Compound
Additional information available to physicians upon request. ELI LILLY AND COMPANY, INDIANAPOLIS, INDIANA 46206.
Lilly
700807

Continuing a Tradition

In the summer of 1965 a tradition was born. Conceived with caution, it was the first medical historical number of the Journal. At the time, editorial hope was expressed that it would be the first of many similar issues dedicated to the preservation of Florida medical history. This hope was reinforced the following summer with the appearance of the historical number, which contained greater variety and volume of material than its worthy predecessor. At that time, the thought was expressed that the two efforts might stimulate more Journal readers to become writers.

As preparations proceeded for a third historical number, it soon became apparent that there would be no problem in collecting enough material. To the contrary, your editors found themselves blessed with a plethora of articles, many from new authors. Our task became one of selectivity.

Thus we arrive at the third in what we hope will become a continuing series of contributions to our state's medical annals.

We are especially honored to have in this 1967 historical number a guest contribution from our colleague Joseph I. Waring, M.D., distinguished medical historian and editor of the Journal of the South Carolina Medical Association. To reinforce our already close ties with our historically eminent sister state, Dr. Waring has given us not only a concise biographical sketch of Dr. John Moultrie Jr., the South Carolina physician who later became lieutenant governor of East Florida under British rule, but has provided the first known English translation from the Latin of Moultrie's widely acclaimed medical school thesis on yellow fever. For additional information on Dr. Moultrie and other interesting medical lore affecting our general section and occasionally Florida specifically, we would suggest reading Dr. Waring's "History of Medicine in South Carolina 1670-1825" (1964), copies of which may be obtained from the author, the publisher (the South Carolina Medical Association) or the printer, R. L. Bryan Company, Columbia, S. C.

In the biographical line, the 1967 historical number contains a variety of contributions by Florida medical authors. Dr. Edward Jelks has given us a new look at Dr. John Gorrie, physician and inventor of the artificial ice-making machine. Dr. Wilson T. Sowder, our present State Health Officer, has furnished us a fascinating description of the life and times of Dr. Joseph Y. Porter, who the year following his FMA presidency became Florida's first State Health Officer. Dr. Alvan G. Foraker has brought more recent history into focus with sketches of the state's pioneer pathologists.

To add the "spice of life," three widely different articles round out the issue. Author Ann Stover, wife of an FMA member, has provided us a graphic, and at times appalling, picture of the treatment of Florida's mentally ill from past to present. Dr. Max Michael has contributed a light but carefully researched compendium of materia medica utilized over the years in the state. Lastly, but by no means least in any way, our own noted Florida medical historian Dr. William Straight has given us an excellent and intriguing history of Miami's Jackson Memorial Hospital, the state's largest general hospital, which grew from meager beginnings in the not-so-distant past.

In addition, the Journal takes pleasure in initiating, appropriately in this historical number, a new monthly department entitled "50 Years Ago in the Journal." It is hoped that readers will find enjoyment in some of the topics being thought about and written of a half century earlier.

Advertising of yesterday and today may be found throughout the issue. We trust that you will review and enjoy each page.

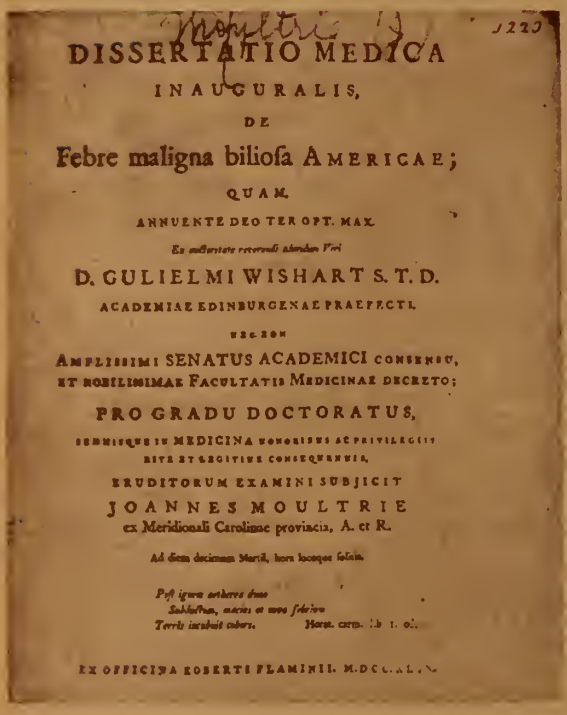
To all who contributed to this issue, we owe deep thanks. May it be a fitting continuation of the tradition.

T. M.

John Moultrie Jr., M.D.

Lieutenant Governor of East Florida
His Thesis On Yellow Fever

Joseph I. Waring, M.D.



DISSERTATIO MEDICA
INAUGURALIS,
DE
Febre maligna biliosa AMERICAE;
QUAM,
ANNUENTE DEO TER OPT. MAX.
Ex auctoritate reverendi admodum Viri
D. GULIELMI WISHART S. T. D.
ACADEMIAE EDINBURGENAE PRAEFECTI,
NEC NON
AMPLISSIMI SENATUS ACADEMICI CONSENSU,
ET NOBILISSIMAE FACULTATIS MEDICINAE DECRETO;
PRO GRADU DOCTORATUS,
SUMMISQUE IN MEDICINA HONORIBUS AC PRIVILEGIIS
RITE ET LEGITIME CONSEQUENDIS,
ERUDITORUM EXAMINI SUBJICIT
JOANNES MOULTRIE
ex Meridionali Carolinae provincia, A. et R.
Ad diem decimum Martii, horis locoque solitis.
Post ignes aetherei dona
Salubriora, aquis et mane foliis
Terris invehit cibos. Horat. carm. lib. 1. od.
EX OFFICINA ROBERTI FLAMINII. M.DCC.LI.

Among a number of Scottish physicians who came early to South Carolina was Dr. John Moultrie who arrived in 1728 and soon established a respected place in medical activities of Charleston. He was one of the first physicians of his new country to conduct a practice which became almost entirely obstetrical.[1] To his son John Jr. he imparted his own knowledge and skills, then sent him to Edinburgh to complete his medical education. There in 1749 John Moultrie Jr., the first American-born diplomate at his University, presented an inaugural dissertation on yellow fever *(De Febre Maligna Biliosa AMERICAE)*, a disease of which he could speak with authority, having suffered an attack of it in the Charleston epidemic of 1745.

Soon after graduation the young physician returned to Charleston and entered practice. He was involved in local civic affairs as a justice of the peace and representative in the General Assembly. Concern with planting and politics seemed to overshadow his interest in medicine, for there is no record of any remarkable activity in his profession during his stay in Charleston.[2]



John Moultrie Jr., M.D.

When the English Government of East Florida was formed in 1764, John Moultrie Jr. was made a member of the Governor's Council, and later became its president and lieutenant governor, serving for three years as chief executive in the absence of the Governor. In Florida he took up much land, built a stone mansion with park and garden, and went into extensive planting. He participated actively in the development of the country, but political quarrels and the cession of Florida to Spain in 1783 proved the ruination of his fortune. Unable to tolerate the new requirements for citizenship, he removed his residence to England, where he died in 1798.

Moultrie's Edinburgh thesis appears to be the first description of yellow fever to come from the American continent. It offered no new knowledge, but in clear Ciceronian Latin gave a lucid clinical account of personal experience with a disease of unfortunately frequent occurrence in the author's native town.

This *Dissertatio Medica Inauguralis de Febre Maligna Biliosa AMERICAE* appeared first at Edinburgh in 1749. In 1768 it was again published (in Latin) in Longosalissae (Langensalza), edited by E. G. Boldenger. It was translated into German by Karl Paulus[3] in 1805, and into French by M. Aulagnier in the same year.[4] As late as 1855 Rene La Roche[5] was quoting Moultrie freely as an authoritative observer. This is a truly unusual record for a graduation thesis!

In the introduction to the new edition 1768 Boldenger remarks:

"After reading it, I decided immediately to prepare a new edition, realizing that this disease merited attention as being in the category of the most dreadful. Its character has been quite carefully described by the distinguished author, its symptoms observed, and its causes investigated, disclosed, and, through sections of cadavers, further confirmed with all due care. I have read here and there in various authors much about this fever, called in English Yellow Fever, but, as far as I recall, no one has so precisely described and explained this dread disease as the distinguished Moultrie, who easily deserves to be rated the foremost."

The original pamphlet of 35 pages, including 23 pages of text, a page of prescriptions and seven pages of meterological tables compiled in Charleston, has apparently never been published in English. It is too long for full printing, but the following excerpts give some indication of its contents.

The thesis begins with some general philosophical comment on the function of medicine, followed by an outline of what the author with due modesty proposes to discuss, then proceeds into a consideration of "The Yellow Fever or Black Vomiting."

There follows a full description of the symptoms of the acute onset. "This disease rages in the northern regions of America during the months of June, July and August; at which time the almost suffocating heats of the sun, from which I shall later attempt to show its origin, and the heaviest rainfalls occur annually, as the weather reports appended to this dissertation testify. In the American islands situated not far from the equator, where intense heat is dominant for almost the entire year and there is never any severe cold, it attacks not only in the aforementioned months but in the others as well.

"City dwellers, hardy, sanguine working people exposed to the sun's rays and to the night air, heavy drinkers, seamen in short, persons of the lower class and especially newcomers suffer most often from this disease; rarely the well-to-do, the young below the age of puberty, women, and such

as lead lives exempt from hard work and not much exposed to the heats of the sun. Strangely, it is noteworthy that few of the Ethiopians ever contract this disease although they are the most exposed to all these deleterious conditions. They do, however, often contract a hot fever in its stead. Not all persons, even though they are endowed with the same temperament and observe the same norm of living, are equally subject to this fever. It rather seldom attacks those who are acclimated, rather frequently those who are not; so that to the indigenous Indians it is completely unknown and the Ethiopians, from the parched regions of Africa, are seldom attacked. Quite frequently, however, it attacks Europeans who have for some time become acclimated, but especially newcomers, who are its chief victims and to whom it is most deadly. Freezing weather or even cold air always ends a violent spell of this disease."

After this is an account of the second stage of the disease, with jaundice affecting first the eyes and neck, then all the tissues of the body, then the "dreadful symptoms" of the third stage are enumerated—hemorrhages, cold sweats, hiccups, convulsions, deliriums or lethargies.

"A steady and exceedingly acute pain of the forehead, lassitude, and a sudden weakness without apparent cause, dizziness, chill and shuddering, very often cold sweats. These symptoms are immediately succeeded by a hot fever, a very annoying anguish, great oppression, and intense pain of the precordium, of which the patient is keenly aware, applying his hand to the affected part; also an aching of the loins, which often extends to the body's extremities and seems to be lodged deep within the bones; commonly a rapid, weak, hard and contracted pulse; sometimes one just as hard and fast but energetic; a bulging and burning of the eyes and a sort of ophthalmia, the face, neck, and chest very red; very great heat around the vital organs; the skin at times dry and withered but often wet with perspiration; respiration heavy, panting; a loathing of food, continuous nauseas and vomitings; diarrhoea; much restlessness and sleeplessness, or if perchance sleep does occur, only an intermittent and by no means refreshing one."

Moultrie apparently had some experiences in autopsies on the yellow fever patients. He describes the widespread jaundice, the inflamed state of the stomach and intestines and changes in other tissues. "Now livid spots break out over the entire body, and the patient, deprived both of reason and external senses, feels no pain or discomfort. Cruel death finally claims the poor wretch. . . ."

"So much for the history of the disease; let us now proceed to its causes. The North Americans declare that this deadly disease was brought to them from the American islands; the inhabitants of these islands, however, deny that it is indigenous with them, for all of them desire to escape the disgrace attaching to a most fearful disease. At any rate, there are sound reasons that point to its origination there; and if in this variety of opinions I may be permitted to advance my own, I could easily think it to be equally indigenous to America and its regions and also to any others that are just as hot. And yet it must be admitted that it attacks more frequently in the islands just mentioned than in North America, because in them the heat is more intense and longer lasting.

"The proximate cause of this malady seems to be the acrimony of the fluids; and of antecedent causes, chiefly the intense heat of the air and excessive movement of exertion. Moreover, the copious exhalations and putrid miasmas which, chiefly by the force of the heat, are lifted into the air from swamps, pools, and subterranean places and which abound especially in the immense forests in America with their great number of poisonous trees, must be reckoned among the antecedent causes of this disease. . . .

". . . Also excessive imbibing of spirituous liquids, to the extent that it increases the body's heat and kindles a kind of semblance of fever, is appropriately charged as one of the antecedent causes of this disease."

Moultrie then offers an interesting observation that the common "prickly heat" of hot climates, due to the same acrimony of body fluids, is a safety valve, for ". . . It is observed that those who suffer these eruptions almost always escape untouched by diseases."

He goes on to say: "I must now discuss the chief antecedent causes; the intense heat of the air and excessive exertion, by means of which the proximate cause, viz., the acrimony of the fluids, is produced. 1st. Through heat and activity animate substances become putrid, and, necessarily, sharp."

On the question of contagion he took a middle ground.

"Almost all authorities are persuaded that this malady is contagious. Unquestionably, when it is prevalent all persons are liable to it, seeing that they are surrounded by and breathe in the same air, and the sharp, semiputrid exhalations are continuously issuing from bodies of the sick and the air of the place where the patient lies is filled with them . . . infection which the healthy no less than the sick take in not without great harm. On the other hand, I have seen a great many persons who sat daily by sufferers from this disease, but, protected against the harmful effects of the air and against excessive exertion, they escaped unaffected." But, he says,

"I cannot believe with others that this disease is propagated by contagion from one province to another, unless the air is suitable for producing it. In the year 1745 it was raging most violently in South Carolina, when it was plainly evident that contagion from another province was not the cause. For the first person to be victimized that year was a sailor. . . ."

Now come the theoretical considerations.

"This disease is prevalent more often among seamen and persons accustomed to hard work than among the well-born and the leisure class because they are more exposed to all the causes that produce it, leading, as they do, intemperate lives and guzzling great quantities of unhealthful spirits. This could easily be observed, because when, on the unanimous advice of doctors, each man's allotment of spirits was mixed with three parts of water and distributed among them three times a day, the vehemence of the disease decreased immediately. On the contrary, the well-born, who imbibe abundantly of a strongly acid gentleman's drink called *Punch* in English usually escape without ill effects; for by the aid of this drink the alkalescence of the fluids is regulated or checked, copious sweat and urination are promoted, and the sharp parts of the fluids are expelled through the pores of the skin and the kidneys; however, the more temperate the life they lead, the less susceptible they are to the disease. Whence it happens that none of the natives and so few of the Ethiopians in these regions are seized by this disease, I confess I do not know; unless it may be that they perspire much more freely than Europeans, and what is excreted by the sweat is very alkalescent and sharp, being possessed of a foul odor and stench, so that the sharp fluids seem to be expelled in this way and to be not as much excited by the hot air."

This continues in detail for some pages in terms not applicable to our present concepts of pathologic physiology. Further discussion of symptoms follows.

"The violence of the fever seems to be diminished after the yellow effusion, for the pulse is weak and tenuous, the gangrenous stage is not present. The urine and the colliquative feces become black, since, from the vehemence of the fever, the humors are exceedingly putrid; as a result of the weakening of the solids and the dissolution of the fluids the colliquative sweats are suspended, which, together with the diminution of the fever, accounts for the fact that the tongue becomes cleaner and more moist in this stage than in the former. Now the patient is seized by a coma, resulting from the matter of the disease blocking up the very delicate vessels of the cerebrum, and Nature, wracked by an anxious solicitude, is, as it were, forced to rest."

And then a word on immunity: "It is falsely supposed by some that those who have once been victimized by this disease never incur it afterwards; but this groundless opinion is contradicted both by reason and experience, for I have seen poor creatures who have twice suffered from this disease."

Prognosis is discussed at some length. "The magnitude of the danger is always in inverse ratio to the duration of its stages, for brevity is dangerous and vice versa, inasmuch as a speedy progression of the symptoms denotes that the disease is violent and dangerous; for if the yellow effusion should appear on the second and third day, it is a bad omen, especially if the pulse is weak; then certainly pale death is knocking at the door with ill-omened foot."*

And now comes an account of the moderate treatments which Moultrie approved, with certain animadversions on those of the competitive quacks.

"The prognosis of the disease finished, the curative method must now be discussed; which, considering the nature of the disease as previously related, is without doubt very difficult. But it is rendered much more difficult by the bad treat-

*An echo from Horace—Odes I. 4. 13.

ment of quacks and empirics, who rashly prostitute our profession to the detriment of the sick. For in all stages of the disease they still employ that white eagle [calomel], phlebotomy, emetics, too strong cathartics, vesicants, alexipharmics and very hot aromatics, etc., which nevertheless are not seldom harmful.

"1st. They administer calomel to dissolve the viscosity of the blood, as they aver; but in almost all inflammatory diseases viscosity is always present during the first period. Who then but a tyro and an amateur would administer calomel in the case of an inflammation? . . ."

"2nd. Phlebotomy cautiously and skilfully prescribed is unquestionably sometimes very helpful; but these ridiculous quacks sever the vein in all stages of the disease, for the strong and the weak alike . . . an error which I have often observed to be fatal; for after an improper use of phlebotomy I have seen induced a deprivation of strength, always fatal. Moreover, if this fever originated from an obstruction or a dislocation, no defect inhering in the bloody mass, certainly a blood-letting would be beneficial; but since in this malady the cause of the fever is the acrimony of the fluids, it is necessary to remove the cause, viz., the acrimony, before the effect. To this end, however, the severance of a vein is of very little use unless the fever be violent. When a violent fever is indeed present, a blood-letting can certainly be beneficial; for it not only mitigates the graver symptoms but removes both the heat and the attritus and necessarily checks the increase of the acrimony.

"3rd. Regarding emetics. Incision of cadavers shows the stomach very much inflamed. Emetics aggravate the inflammation, increase the violence of the fever as a result of the activity of vomiting, and are therefore harmful. . . ."

"A great inflammation is present in the intestines; therefore strong cathartics are harmful, for they irritate the inflammation, induce prostration of the strength, create hypercatharsis (to which the patient is very prone) and purgings of the stomach, finally depriving the patient of life and pain alike.

"Moreover, after inducing prostration of the strength with their strong cathartics, phlebotomy, etc., these mountebanks immediately administer calefacients and vehement aromatics in an attempt to restore the strength. They also administer these remedies during the early days of the disease to promote sweatings, but in this inflammatory disease the effects of the strong calefacients are exceedingly dangerous.

"Having remarked on certain dangerous remedies employed in this disease by unskilled quacks, it now remains for us to detail a more reasonable method of cure, better suited to the nature of the disease.

"The following seem to me to be the indications of the cure, and therefore the best curative method noted by me is accommodated to these indications:

"Let the patient be kept in a spacious room where he can breathe in plenty of fresh air, and let him not be suffocated by a heavy burden of bed-covers, which ought to be quite light. For if the patient, already burning with excessive heat, should be closely confined in bed, fortified by clothing so that the air is shut in on all sides, it (i. e., the air) clings as atmosphere to the warm vapor steaming from the patient's body and its own heat is increased, since it lacks the cooling of the freer air; for our bodies are warmer than the common air in which we live. Moreover, in these patients, semiputrid exhalations are continuously issuing from the body, exhalations that are annoying even to the healthy persons attending them; the air of the sick room is shortly filled with and polluted by these exhalations, and so requires frequent renewal. . . ."

"The employment of a warm regimen is attended with great danger. Therefore alkalescent, spirituous, aromatic [substances], also all stimulants and oily substances must be avoided, since these, through heat and motion, incline toward acridity and necessarily augment the disease. Slightly sour, bland, cooling substances are most suitable. . . ."

"Since it is by his excretion that nature attempts to expel morbific matter from the body, and certainly the safest and easiest way, the promotion of perspiration from the beginning of the disease is therefore highly beneficial, and this—as has been stated above—is best effected by dilutants and tenuous, subacid sudorifics; These also are best retained in the stomach when warm; but all diaphoretics are to be avoided, for they increase the fever through stimulation.

"Bland, emollient enemas are very effective; for not only are the putrid feces that have col-

lected in the intestines flushed out and all these parts fomented, but in addition the emollients and antiphlogistics received in the intestines are absorbed by the relaxed and cleansed tiny mouths of the mesenteric veins and thus become thoroughly mixed with the blood; whence is obtained the best and swiftest dilution of the same. . . ."

". . . And since the patient suffers from nausea and continuous vomiting, frequent bland enemas, viz, from roots of marshmallow (altheae), leaves of mallow, barley seeds, seeds of oats, rice with nitrate cooked in milk with kitchen sugar, injected three or four times a day and retained in the body to the extent that is comfortably possible, are in the highest degree conducive to nourishing the body while ailments taken through the mouth are being rejected through continuous vomiting. . . ."

"The bowel should be cautiously bound, for otherwise nature, from weakness, will not be able to hold out to the end of the disease. For checking the bowel, therefore, I think it best to experiment with mixture (B); and if it does not have the desired effect, then only must anodynes be employed, and they must first be injected in enema (C) since it takes effect very swiftly; and if these also should fail to bind the bowel, then I would prescribe a bolus (D) by drinking additionally a spirituous draught composed of aromatics, this to be repeated for as long as may be necessary while at the same time the use of mixture (A) must be discontinued.* I have heard that the doctor whom I have recently mentioned quite successfully employed 'Sachar. Saturn.' in small doses, which is probable, inasmuch as it is very astringent and I believe that it is very useful in checking diarrhoea. I should therefore use boluses (E) if the bowel could not otherwise be bound. The patient very often suffers from continuous vomiting for the checking of which I have seen nothing better than mixture (F) if only he take nourishment in small amount but often, lest the stomach suffer pain.

". . . If there should be fear of prostration of strength [resulting] from an excessive flow [of blood], then a styptic, e. g., cold water, vinegar, spirit of vitriol diluted with water, or (G) must be employed to check it. . . ."

*The remedies prescribed by Dr. Moultrie were basically (A) barley and potassium nitrate, (B) Gambir and "crabs eyes" in wine, (C) Mallow, camomile, and juniper as an emollient and carminative mixture, (D) Theriac, a shotgun panacea of the time containing opium, (E) Acetate of lead, an astringent, (F) Wormwood, a substance used for intermittent fever before cinchona was known, G) Alum, lead acetate, and (H) vitriol, ascending in quality as astringents.

"If in this stage of the disease any signs indicate the presence of gangrene, it is all over; for I have noted that nothing does any good. Peruvian bark may possibly be administered, but I have never seen anyone get well after the spread of gangrene.

"The bark is indeed very efficacious for stifling gangrenes and arresting their spread if annoying vomiting does not ensue, but it is hard to keep down without nausea. I would use perhaps decoction (H) as an extract, since the size of the dose is rather small and therefore more easily retained in the stomach. . . ."

"To conclude; Let me advise foreigners intending to depart for these hot regions to protect themselves with the utmost care against the heat of the sun and the cool night air. Let their food be light and cooling, especially acid inasmuch as the acrimony of the fluids is thereby regulated—let them avoid as far as possible all alkalescents and spirituous substances, which inflame the juices of the body and make them more alkalescent and therefore more susceptible not only to this but also to other diseases peculiar to these regions. Finally, let them avoid excessive exertion and always keep the perspiration free flowing, for in this way are expelled the very alkalescent and sharp particles which, if detained, might through acrimony engender diseases.

"Thus, as I hope, they will escape this most loathsome disease, which, with their particular advantage in mind, I have attempted to touch upon, *ad nauseam* perhaps, yet to the best of my ability."

Thus Moultrie described from first hand experience a disease which was to be for many years of major concern in America and elsewhere. His observations are clear, his treatment conservative in the light of his times. His thesis might be considered as a valuable summary of the knowledge of the time, and a useful manual of practical treatment.

References

1. Joseph I. Waring: A History of Medicine in South Carolina 1670-1825—p. 268. Columbia, The South Carolina Medical Association, 1964.
2. Eleanor W. Townsend: John Moultrie, Jr. M.D. 1729-1798. Ann. Med. Hist. 3rd Series 11:98:109.
3. Ueber das gelbe fieber. mit zusaten und. anmertungen—von Karl Paulus (Bamberg and Wurzburg 1805).
4. Traite de la fievre jaune, Trad. par M. Aulagnier (Paris 1805).
5. Rene LaRoche: Yellow fever. 2 vols. (Phila., Blanchard and Lea 1855).

For the translation of Moultrie's thesis the author is indebted to Mr. Maurice McLaughlin of the Porter-Gaud School in Charleston.

Dr. Waring, 80 Barre Street, Charleston, S.C. 29401.

'Old Timey' Remedies Of Yesterday and Today

Max Michael Jr., M.D.
and
Mark V. Barrow, M.D.

O! Mickle is the powerful grace that lies
In herbs, plants, stones and their true qualities
For naught so vile upon the earth doth live
But to the earth some special good doth give.
. . . Shakespeare
(Romeo and Juliet)

Folk medicine, home remedies or "old timey cures" are often looked upon askance. Nevertheless, a consideration of them can be tantalizing and pungently stir our imaginations. In the present day of polypharmacy, double blind studies, governmental controls of drugs and the fierce competition between pharmaceutical houses, it seems worthwhile to look back at some of the remedies of the past and how some of these have evolved into useful drugs. Others are still in use in our communities in their pristine forms.

Folk Medicine of the Past

Since man's beginning, plants have provided the medicinal remedies for the human race. With his civilization and enlightenment, man produced the herbals which contained the cure-alls of mankind. The Bible contains abundant references to the use of herbals for treatment and for prevention of disease. The structure of even the modern pharmacopoeia is still based on historical knowledge of flowers, herbs, plants and trees and how they may be developed into stimulants, tonics, diaphoretics, emetics, cathartics, astringents, carminatives, poultices, diuretics, demulcents, antipyretics and the like.

Since most of the "sure cures" of the famous herbalists and the old time family remedies have gradually and steadily disappeared from the pharmacopoeias, one wonders if these old timey remedies—these roots and herbs—were based on theoretical grounds almost entirely erroneous and were no more than grand illusions aided at times by charlatanry. As Kipling stated,

Wonderful little when all is said
Wonderful little our fathers knew
Half their remedies cured you dead
Most of their teaching was quite untrue.

Most folk medicines, although highly recommended, likely had no base in fact whatsoever.

From Jacksonville Hospitals Educational Program and Department of Medicine, University of Florida College of Medicine, Gainesville.

Nevertheless, the haunting fact remains that the herb doctor did at times employ many plants whose physiologic actions, though obscure, were real, even potent, and which are not infrequently still employed. An even more challenging thought is that perhaps many useful herbs go unrecognized waiting for fate, serendipity, or less likely, science, to intervene and discover the long held secret.

Lacking the so-called therapeutic sophistication of today, the pioneers, both lay and medical, resorted to empiricism. Treatment was directed toward symptoms. In spite of our derisions at such practices, it is prudent to recall, indeed with a sobering mien, several examples of folk remedies which have evolved to play a dominant role in medical practice even today.

William Withering, a student of botany, learned in 1775 of a family secret guarded "by an old woman in Shropshire" with which dropsy could be "cured." That this family was not the sole possessor of the powers of the fox glove was apparent for Withering knew it to be an old wives' remedy in Yorkshire. In fact, he came across "a travelling Yorkshire tradesman who was vomiting, his vision indistinct and his pulse forty to the minute because his wife made him drink a too concentrated brew of fox gloves leaves." Although the old woman of Shropshire brewed her potion out of 20 different herbs, Withering wrote: "It was not very difficult for one conversant in these subjects to perceive that the active herb could be none other than the fox glove."

Quinine is another remedy which probably did as much as any single medical discovery to alter the course of history. Its derivation from cinchona bark and discovery by Indians are well known.

Still another equally fascinating tale is the discovery of Rauwolfia serpentina by two Dutchmen in 1887. This medication was widely used in India in ancient times but reached modern pharmacognosy only recently. Finally, the introduction of the bark of the willow tree (salix) for treatment of rheumatism by the Rev. Edward Stone in 1763 ultimately led to the purification of salicylic acid and later the production of aspirin.[1]

Even though the modern pharmacists' shelves contain a bewildering number of drugs of which an astounding proportion have been introduced within recent decades, folk medicine is not dead. It is still practiced throughout the world, the United States and the state of Florida.

It is difficult to pinpoint any remedies or modes of treatment originating in Florida. Many were brought by early settlers from territories to the north and some were undoubtedly learned from the Indians. Perhaps some originated here when it was necessary to turn to sources at hand—the flora of a region—to relieve suffering.

During the Civil War, Francis P. Porcher prepared a "Brief Note of Easily Procurable Medicinal Plants to be collected by soldiers in any part of the Southern States."[2] With one man detailed from each company and regiment, a fresh supply of these herbs was made available for use of the Surgeon "at less trouble and expense than if it was produced by the Medical Purveyors."

A few quotes and recommendations regarding several of these merit note:

> Wild jalop—If this can be found it can be used as a laxative in place of rhubarb or jalop, or wherever a purgative is required. Every planter in the Southern States can produce the opium, mustard and flax seed that is needed for home use.
>
> Blackberry Root—A decoction will check profuse diarrheas of any kind. The root of the Chinquapin is also astringent.
>
> Thoroughwort, Bone-set— . . . drank hot during the cold stage of fever, and cold as tonic and antiperiodic, is thought by many physicians to be even superior to the Dogwood, Willow or Poplar as a substitute for quinine. It is quite sufficient in the management of many of the malarial fevers that will prevail among troops during the warm months.
>
> Sassafras . . . , whenever a soldier suffered from measles, pneumonia, bronchitis or cold, his companion or nurse was directed to procure the roots and leaves of Sassafras and make a tea.

In describing Gentian and other tonics, Porcher admonished, "It is not intended that a blind or exclusive reliance should be placed upon them—but they are recommended to supply a great and pressing need."

Thus, even though the prescriber cast some doubt as to the efficacies, it takes no stretch of the imagination to visualize the returning Johnny Reb recounting the tales of cures he witnessed and implanting into his culture additional old timey remedies.

It seems that the search for cures for disease in the environmental flora has been the chief factor dictating what was used. Indeed, the Rev. Mr. Stone used the Willow bark for rheumatism which

was seen most often in persons living in low wet areas because he thought that "God in His mercy had certainly placed in these areas some antidotes for the pain." This approach is not too dissimilar to that which is presently used in seeking new drugs, particularly antibiotics.

Records of many of the folk remedies used in pioneer days in Florida are available and as will be seen later many of the remedies still are in use. A Civil War "receipt to cure the dropsy" was recently found.[3] It contained eight simples (a single remedy) consisting of a mixture of Jallop (a purgative), Gambouge (a cathartic and diuretic), Sol Nitre (a diuretic and diaphoretic), Socret of Allows (a purgative) and medical Coperas (a purgative) to be taken along with a second concoction consisting of Sweet Spirits of Nitre (a diaphoretic), Buech (a diaphoretic and diuretic) and Balsam Copeovia (a cathartic and diuretic). It is no wonder the "dropsy" might improve with all the cathartics, diuretics and diaphoretics purported to be in these preparations. The recipe ends with the comment, "If the pulse is very high, give about 25 drops of the tincture of Digutallice every day to regulate them."

Spider web pills and rusty nail tinctures had their place in most homes of the last century along with numerous plants gathered by persons taught by word of mouth through several operations.[4] Bone-set tea was good for fevers—Jimson weed for itch, asthma and rheumatism. Sage of Sassafras tea was good for "breaking out" measles, mint brought "warmth to the stomach," a tincture of rusty nails helped to bring the color back to pale faces and various remedies improved vitality and aided in the prevention of aging. Thus one homespun poet said:

> May friendship and truth
> Be with you in youth
> And catnip and sage
> Cheer up your old age.

Folk Medicine Practiced Today

Folk practices are more apt to be noted nowadays among the farm folk and among those of a lower socioeconomic stratum. The recent upsurge of publications such as "Folk Medicine in Vermont," "Green Medicine" and "Herbal" have heralded renewed interest in this area once thought to be so important. The reason for this awakened interest is not clear; perhaps historians have whetted interest, perhaps the romance of the dream of seeing herb seekers in foreign jungles and on distant prairies has been enticing or perhaps there is again the desire to get somewhat away from the synthetics and back down to earth and its products. Whatever the reasons, the interest is real.

Recently a social worker at the University of Florida, Alice H. Murphree, obtained a list of some 40 herbs used today in a rural area.[5] In the process of obtaining a base line survey of health resources in Lafayette County, located in northwest Florida, she had the unique opportunity of interviewing at length some 70 households, many of which contained "old timers." Since no hospital is located in this county, the scientific and medical care consists of regular attendance of a public health nurse along with a public health physician manning a clinic once weekly. Thus residents are either forced to travel outside this county or to resort to other means of medical care such as utilizing old fashioned remedies of their parents and grandparents today; frequently, reliance is placed upon the latter.

As an aside and because of parenthetical interest, Mrs. Murphree frequently asked her interviewees about old timey remedies of folk medicine and perhaps surprisingly noted that all residents knew about these remedies and most had or were having personal experience with them. Not only were the common names and uses of a wide variety of local herbs obtained but on a return visit she acquired from the residents samples of these medicinal plants and later had them identified at the Herbarium at the University of Florida. All of these herbs were from the local environment. Most were "sworn by" by more than one person and most had been used in recent years; frequently the specific ingredients and correct dosages were limited to some of the oldest informers.

We have taken the names of these plants and arranged them in alphabetical order according to their scientific name, listed their uses according to the Lafayette County residents in one column and the usefulness as described in several bulletins, pharmacopoeias, herbals and botanical texts in another (table 1). Virtually all the families interviewed had little access to herbals and other publications on the medicinal plants; furthermore, they invariably volunteered that the knowledge was passed to them by word of mouth for several generations. Of the 40 plants, 22 show a surprising correlation between modern folk usage and the

purported usage according to various so-called scientific publications containing information about them. Eighteen others, including Milkweed (Asclepias humis grata) for warts; several grasses and vegetables for fevers, infections and rheumatisms; Sting nettle (Cnidostulis stomulosus) tea as a sexual stimulant; Rabbit tobacco (Eriogomum tomentosum) for asthma; Life everlasting (Gnathalium purpureum) an "indian snakebite remedy" and the common prickly pear used as poultices for cuts, sores and bruises, had no counterpart in material available to us.

A pamphlet prepared by Johnson in 1960 describes important medicinal plants in Florida containing 53 "major" plants among them such as Discoria (an acid resin that increases flow of urine), Cajeput, Storax (exudate of the sweet gum tree used in various products for treatment of colds) and Ginseng (used as a stimulant because of its glucosidal content).[6] This was written in response to "the continued interest of Floridians in gathering or collecting medicinal plants for possible profit" and outlines methods of collection, culture, gathering and drying of these wild species.

This limited survey of folk remedies makes no pretense at completeness. It is hoped it will whet the readers' appetites to inquire more about such remedies from their patients both out of interest and perhaps as an aid or indeed as a contributing factor to their illness.

Other Folk Customs of Today

Besides remedies there is a variety of other beliefs and customs practiced today. We wish to point out a few of these so-called "old wives' tales" that can still be encountered. A tour of the wards of a hospital which has patients from the lower socioeconomic level and those of a rather primitive culture often will uncover some rather startling and humorous customs. We have observed many of these ourselves and are indebted to several other observers for passing some on to us.

When the home remedy she had used failed to relieve symptoms of a 40 year old Negro woman with jaundice of three weeks duration, she sought hospitalization. This potion which she learned from "a neighbor lady" was made by placing nine large rusty nails, all of the same size, in a pint of whiskey. After standing over night, the remedy was ready for use. It was to be taken in doses of one teaspoonful three times a day, although the informant admitted that often the dose was larger. The type of whiskey made no apparent difference; however, "shine" was to be preferred.

Although most areas of Florida are devoid of clay, eating of this earth is still practiced by a large segment of the population. Where this began and what it was to do are difficult to pin down. Perhaps this form of pica supplied some magic missing elements. It is not, however, without harm, for clay eating interferes with iron absorption and can contribute to iron deficiency anemia. In children, dirt is frequently fed for the rather startling reason of "treating the worms."

Starch eating is also a not uncommon practice. To the children, it is fed for indigestion and to adults for an easier and less complicated pregnancy. Often the user becomes "addicted" to the practice and continues to ingest several boxes a day. It is interesting that it does not seem to result in obesity. Closely allied to this custom is the practice now seen principally in the more rural areas of placing a sharp axe under the bed to cut the pains of labor.

The ritualistic nature of many of the remedies is typified by the following recommended treatment for asthma. Eleven red ants are placed in a can nailed above the door to the dwelling. Eleven days later the victim returns and says the Twenty-Third Psalm. Undoubtedly the anxiety of the protracted wait results in an excessive endogenous production of adrenal steroids.

The twisted copper wire around the joint for the relief of arthritic symptoms is still a rather commonplace phenomenon in certain cultural groups. Many a physician has been startled the first time he observes a filthy string braided in a mysterious fashion around the waist. Adding to the unaesthetic qualities is the generous application of kerosene to the amulet. One would assume this to be suitable for abdominal ills only, yet such is not the case; it is good for a variety of symptoms, signs and syndromes. The origin of this custom is hidden somewhere in the distant past, yet it takes little imagination to see the similarity to certain tribal voodoos of Africa.

An isolated observation at the Duval Medical Center several years ago was fascinating but frustrating to pursue. A 25 year old Negro man was being managed in the outpatient department for diabetes. Attempts at control were fruitless; he

Table 1.—Florida Folk Medicines With Some Possible Scientific Bases

Common Name*	Usefulness According to Residents of Lafayette County	Usefulness According to Publications**
1. Onion	"Roasted onion juice in ear ache"	Roasted onion juice antiseptic; useful in ear ache
2. Virginia snake plant	"Tea to purify or build up the blood"	A tonic, stimulant tonic, antitumor activity
3. Cabbage	"Wilted leaves draw out poison"	Breaks open carbuncles
4. Buttonwood	"Root in whiskey for dropsy"	Contains glucoside cephalanthine
5. Jerusalem Oak	"Roots boiled and candy syrup given each spring"	Contains an antihelminthic, chenopodium oil
6. Gopher Grass	"Tea stops fever and for gout"	A fever grass
7. Dog Fennel	"Tea from roots will sweat off fever"	Contains a bitter principle, eupatorin, which is a diaphoretic
8. Low Bush Myrtle	"Tea good to maintain labor"	A stimulant and astringent producing coughing and sneezing
9. Catnip	"Tea for colic or hives"	Contains tannin and a volatile oil useful in colic
10. Pine	"Sap stops bleeding; resin for boils"	Controls passive hemorrhages and is antiseptic
11. Poke Plant	"Root tea good for ground itch"	A poultice used by Indians, contains a toxic alkaloid, stimulates plasma cell production
12. Wild Cherry	"Boiled gum syrup good for cough"	Contains amygdalin which yields hydrocyanic acid, a sedative for coughs
13. Black Root	"Tea from roots cause abortion"	Used by Indians as a drastic purgative
14. Red or Post Oak	"Tea from bark good for colitis or ulcer"	Contains tannic acid and is astringent, good for diarrhea
15. Trumpet Plant	"Tea from root for indigestion or diarrhea"	Used by Indians for dyspepsia
16. Sumac	"Tea from roots; poultice for erysipilis"	Used by Indians for wounds and topically for skin conditions
17. Sassafras	"Tea from roots builds up the blood and in measles"	Used by Indians for syphilis and for febrile diseases
18. Queen's Delight	"Tea from root to purify the blood"	Contains a volatile oil, sylvacrol, which purifies blood and cures syphilis and purges
19. Deer Tongue	"Pillow of leaves for asthma"	Contains Coumarin, a flavoring, a demulcent and diaphoretic
20. Mullein	"Tea from leaves good for feet swelling"	Contains volatile oils and mucilage, a good demulcent
21. Periwinkle	"Tea from dried plant a good blood tonic"	Contains Vinblastine and Vincristine used in Hodgkin's
22. Prickly Ash	"Root tea clears V. D."	Contains alkaloids and phenolic compounds including berberine; useful for syphilis

*Scientific name (numbers refer to numbers listed under "Common Name")

1. Allium Cepa
2. Aristolochia serpentaria
3. Brassica oleracea
4. Cephalanthus occidentalis
5. Chemopodium ambrosioides
6. Chrysopsis gramimfolia
7. Euputorium compositifolium
8. Myrica cerifera
9. Nepetia cataria
10. Pinus elliottii
11. Phytolacca americum
12. Prunus serotina
13. Pterocaulon undulatum
14. Quercus falcuta or margaretta
15. Sarracenia minor
16. Rhus copallina
17. Sassafras albidum
18. Stillingia sylvatica
19. Trilisa odoratissima
20. Verbascum thrapsus
21. Vinca major
22. Xanthoxlan clara-hercules

**(6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17)

had no infections and to the best belief of the attending physician he was following instructions scrupulously. For some two months, however, his diabetes was out of control until he arrived at the clinic one day with a normal fasting sugar and maintained seemingly good control for several weeks thereafter. To supplement his insulin injections, he thrice daily ingested a tea brewed from Spanish moss. Attempts to induce hypoglycemic effect in rats with an infusion of moss produced equivocal results, although it is quite possible that the technique of manufacture in the laboratory did not meet the rigorous standards of the patient's grandmother who supplied him with his tea. Interestingly enough, we have been able to find little mention of folk remedies using Spanish moss.

A ward supervisor of a pediatric service in a busy county hospital has supplied us with customs that are still seen in patients admitted to her floor. The asafetida bag worn around the neck to ward off infections, particularly colds, is still seen. A tea brewed out of eggshells will flush poisons out of the kidney. Turpentine with sugar and kerosene taken orally are good for colds and respiratory infections. A small crisis occurred a few months ago when a child was to be taken to surgery. Around his neck was a snail shell attached firmly to a string. The mother objected strenuously to having this object removed for this would surely ward off bad omens. It is not certain whether the surgeon himself or the operation was the evil spirit.

An interesting feature that one of our informants passed on to us was that within the past decade she sees these old timey remedies and customs used much less than in the past. It is her belief that this change is taking place because the younger mothers are more educated; they take their children to physicians more frequently rather than listen to the old wives' tales. Nevertheless, these old customs do persist.

Still observed is the string tied around the ankles carefully threaded through a shiny dime. This is good not only for all ills but it serves as a preventive measure for disease in general. Another nonmedicinal, though perhaps preventive, use of string is that tied in nine knots around the waist of the woman who thinks her husband is wandering. This will allegedly deter such peregrinations. These, the rabbit's foot or the buckeye carried in the left pocket, do not truly belong in the class of herbals or old timey remedies, but are best considered good luck charms or preventives.

One could conjecture that some of our so-called modern preventives such as the bacterial cold vaccine are not much different from the dime worn around the ankle since this was heartily endorsed on faith without proof.

A practical nurse told us of the application of poinsettia leaves to the head to cure headache; although she told this as an old timey remedy she quickly asserted, "It does work." What one does in the winter when there are no such leaves in the northern part of Florida could not be ascertained.

A dried tooth worn on a string around the baby's neck helps with his teething. During pregnancy, the mother eats magnesia in cake form to give the baby good strong bones. The taking of a teaspoon of nutmeg a day helps to keep the complexion clear. The recent knowledge of this being an hallucinogenic agent makes one wonder of the result of such use.

Most of these remedies are superstitions based largely on word of mouth efficacy and utilizing materials usually found in the community. The traditional sulphur and molasses in the springtime and sassafras tea are others of the "ancient" remedies that are still in use. It is fascinating to learn that recently introduced materials can be rapidly adopted into the folklore. For example, in certain families if disposable paper diapers are used for the infants, these are to be discarded and not burned since burning the diapers "will cause the baby to develop a diaper rash."

Spider webs have been used in the form of pills for various ills and locally applied to aid with wound healing. Only recently in one of our modern community hospitals an obstetrician who was discharging a patient whom he had delivered informed her that he had circumcised the baby. He admonished her to use only vaseline. "No spider webs and no soot," he reminded her.

Concluding Comments

There is little question but that folk medicine is a dying art, perhaps rightfully so. But who can say that tomorrow Virginia snake root, Buttonwood, Spanish moss, Bush myrtle, Queen's delight or prickly ash will not be found on purification or slight alteration to contain some specific and potent compound? Vincristine from periwinkle has come about in recent months. What lies in the

future for other old remedies with such awe-inspiring names?

It cannot be denied, however, that folk remedies have yielded potent therapeutic weapons when one remembers the instances of digitalis and other drugs cited earlier in this presentation. That most of the remedies of the past and most of the present are without scientific foundation is probable. That there are traces of some compounds in many of the folk remedies which have appropriate pharmaceutical effects is also known. Before one closes his mind to all folk remedies and looks on them with derision, therefore, he must reckon with the fact that some indeed may be efficacious.

But just as many of these old drugs have become looked upon as useless, so many of our present so-called specific medications may well be looked upon as useless placebos by the physicians of years to come. The wholesale removal of organs to alleviate "foci of infection," the widespread administration of thyroid extract for treatment of all kinds of obesity, the routine removal of tonsils to help the child with his growth, the application of mustard plasters for pleurisy, the lavage of the renal pelvis with potassium permanganate for pyelonephritis, the changing dietary fads in management of cirrhosis of the liver, the use of bile salts to dissolve gallstones and barium chloride for Stokes-Adams attacks, the radiation of the thymus in young children to prevent "status thymicolymphaticus" are but a few examples of once well accepted forms of treatment no longer in use which have completed their cycle. Santayana laconically stated, "He who does not know history is condemned to repeat it." Such a frame of mind would help us to be more critical of some of our so-called therapeutic triumphs as well as to keep an open mind regarding new approaches as we look back with a sobering thought to folklore medicine of the past and examine that of the present.

References

1. Duhos, Rene: Mirage of Health. New York, Harper and Brothers, 1959.
2. Porcher, Francis Peyre: Resources of the Southern Fields and Forests, Charleston, Walker, Evans and Cogswell, 1869.
3. Barrow, M. V.: A Civil War Period "Home Remedy" for the Treatment of "Dropsy," Bull. Hist. Med. 40:376-378 (July-Aug.)1966.
4. Cash, LeMoyne, in Florida Times-Union, Jacksonville, November 27, 1950.
5. Murphree, Alice H.: Folk Medicine in Florida: Remedies Using Plants, Florida Anthropologist 18:175, 1965.
6. Johnson, C. H.: Important Medicinal Plants of Florida. Tallahassee, Bull. no. 14, Department of Agriculture, State of Florida, 1960.
7. Lehner, E., and Lehner, J.: Folklore and Odysseys of Food and Medicinal Plants, New York, Tudor Pub Co., 1962.
8. Krutch, J. W.: Herbal, New York, G. P. Putnam's Sons, 1965.
9. Lloyd, J. U.: Pharmacopeial Vegetable Drugs, Cincinnati, Ohio, Caxton Press, 1929.
10. Johnson, L.: A Manual of Medical Botany in North America, New York, Wm. Wood and Co., 1884
11. Grieve, M.: A Modern Herbal, New York, Harcourt Brace and Co., 1931.
12. Kreig, M. B.: Green Medicine: The Search for Plants that Heal, Chicago, Rand McNally and Co., 1964
13. Kraemer, H.: A Textbook of Botany and Pharmacognosy, Philadelphia, J. B. Lippincott and Co., 1907.
14. Allport, N. L.: The Chemistry and Pharmacy of Vegetable Drugs, Brooklyn, New York, Chemical Pub Co., Inc., 1944
15. West, C.: Poisonous Plants around the House, Gainesville, Bull. no. 175A, Agricultural Extension Service, University of Florida, 1964.
16. Barker, E. E., Farnes, P., and LaMarche, P. H. Haematological Effects of Pokewood, Lancet 1:437, 1967
17. West, E., and Emmel, M. W.: Plants that Poison Farm Animals, Gainesville, Bull. no. 510A, Agricultural Extension Service, University of Florida, 1960.

Dr. Michael, 2000 Jefferson Street, Jacksonville 32206.

Draft Dodger—Circa 1875

The drafted man obeys his summons to appear before the board of enrollment unwillingly; he shrewdly revolves in his mind all the probable avenues of escape; and, after a day's work of examination, the surgeon is led to exclaim with Falstaff, "Lord! how this world is given to lying!" The drafted man wears a truss for an imaginary hernia; he complains of pain in the side and haemoptysis in a chest where the respiratory murmur is as distinct as the rustling of the leaves of autumn in a windy day. He has kidney disease, but his complexion is ruddy and his muscles are as hard and elastic as those of a gymnast. He is deaf, or was so last week or last year, and is fearful of a relapse. His poor liver (if he but knew the technical names, it would be fatty, cirrhosed or hepatized) is diseased, and yet he supports a large family by his daily toil. He has rheumatism in every joint; has weak eyes, dyspepsia, asthma; and even confesses himself a degraded onanist from his youth up, in order to evade the peremptory mandate. To substantiate these claims by corroborative evidence, he produces long and wearisome affidavits from his good natured family physician and his sympathizing friends. He stands before you forswearing his strength, his virility, his manhood, and, with a countenance more expressive of fear than that of many a gallows-sentenced knave, he endeavors to evade the just service which fealty and loyalty demand of him in his country's cause.

Submitted by Joseph H. Davis, M.D., Dade County Medical Examiner, from "Baxter, J. H., Statistics, Medical and Anthropological, of the Provost-Marshal-General's Bureau, Derived from Records of the Examination for the Military Service in the Armies of the United States During the late War of the Rebellion, of Over a Million Recruits, Drafted Men, Substitutes, and Enrolled Men," Volume I, Page 257, Government Printing Office, Washington, 1875.

Jackson Memorial Hospital A Half Century of Community Service

William M. Straight, M. D.

Have you ever struggled for breath? It's terrifying and grows more so as the minutes pass. One Saturday night recently, John began to experience this terror for the first time in his life. The tightness of his chest, the wheezing and a pesky cough got worse. A neighbor had said several weeks ago he should see a doctor about his swollen legs but John didn't have much use for doctors; and anyway, where would he get the money to pay the doctor? The outpatient clinic at Jackson Memorial Hospital? He didn't want to go there even though he was eligible. But things were different this Saturday night—he couldn't breathe.

A neighbor drove him to the emergency room and, supported by the neighbor, John walked slowly through the swinging doors. The anteroom was filled with relatives and less ill patients. The admitting clerk, sensing John's serious condition, signalled an orderly who came with a wheel chair and rolled John to a cubicle on the medical side. Although the average emergency room visitor waits three and one-half hours, a triage system is used to speed help to those who are desperately ill. In a few moments a medical resident was at his side and after skillfully chosen questions and a quick examination the resident made a tentative diagnosis of congestive heart failure. An opiate was given to relieve his anxiety, tourniquets were applied to three extremities, oxygen was started, lanatoside was given slowly intravenously and a mercurial diuretic followed the digitalis through the needle. Within a short while the waters began to recede and John's breathing improved; then came admission to the hospital for further observation and adjustment of his medications.

John was but one of over 130,000 patients seen at the Jackson emergency room last year. An average of 364 patients daily are processed through this, the eighth largest emergency room service in the United States. Jackson, today, is the largest general hospital in the Southeastern United States. This is indeed a striking contrast to the City Hospital of 50 years ago.

In the infancy of Miami the small population of relatively young and vigorous people together with the salubrious climate made the doctor business not very lucrative. Increasing numbers of visitors were coming to town, however, and when a visitor became ill there was often no place to care for him. Henry M. Flagler, recognizing the need for a city hospital, suggested a Hospital

Instructor in History of Medicine, University of Miami School of Medicine.

Fund Committee be organized to raise money by staging a social function and banquet around the arrival of his new steamship, "Miami," on its maiden voyage. He agreed to match the money raised and to donate land for the hospital. This and other efforts culminated in a hospital of frame construction on the corner of what is now N.E. Ninth Street and Biscayne Boulevard. This hospital, built at a cost of $6,000 of which Flagler contributed $4,500 and the land, had 24 beds.[1] It is not clear whether this hospital ever received patients. It is clear that within a short time Mr. Flagler reclaimed the hospital and rented it as an apartment building until December 1905, when it became the Florida East Coast Hospital for the employees of the railway which was then pushing its way to Key West. Dr. James M. Jackson was physician-in-chief.

Although lack of financial support had killed this hospital aborning, the need for a community hospital kept cropping up. Thus, on February 3, 1904, when Walter Weatherford, an employee of Correll's Livery Stable, developed a strangulated hernia, Drs. P. T. Skaggs, E. W. Pugh and W. S. Gramling had to operate upon him on a cot at the door of the livery stable while an onlooker fanned the flies away with a palmetto frond. Although carriages came and went through the door, kicking up dust, and a crowd of curious onlookers pressed in upon the surgeons, mirabile dictu, Weatherford made an uneventful recovery and was soon back on the job.

A sudden outbreak of smallpox among the Negro servants of the Royal Palm Hotel that winter stimulated the rapid construction of a "pest house" near the present N.W. Seventh Avenue and 28th Street,[2] which served as an isolation hospital but was too inaccessible for the routine accidents and illnesses which occurred from day to day. Thus, when John Ogiltree was hit by a train which crushed his leg, the only place where he could be lodged and secure medical treatment was the county jail.

A group of charitable men who had organized the Miami Relief Association in November 1903 sought to obtain funds for a cottage of three or four rooms "where the needy and friendless sick may be provided the proper attention." Apparently their efforts did not bear fruit and City Judge John C. Gramling, who was constantly faced with the problem of finding lodging and medical care for sick paupers, organized the Dade County Hospital Association in May 1908 to make another attempt to build a charity hospital. Mr. Flagler again promised two lots, lumber companies offered building materials and the labor unions volunteered labor. The physicians of Miami agreed to give their services free to the indigent and the county and city agreed to pay $9 per month for any of their citizens unable to meet the expenses. Each time Judge Gramling and his friends would submit a choice of lots, however, Mr. Flagler's managers would reject the request for various reasons. Although Judge Gramling and Dr. E. K. Jaudon favored raising money and buying two lots, other members of the Dade County Hospital Association preferred to keep trying to find lots suitable to Flagler's managers.

Finally, on May 25, 1909, spurred by further incidents, the Dade County Hospital Association was reorganized to purchase land and get the hospital built.[3] The prime movers in this project were Judge Gramling; Father A. B. Friend, the priest of Jesu Church; Dr. C. J. Erickson, a druggist; Mr. Frank B. Stoneman, publisher of The Miami Metropolis; Mr. T. W. Jackson, an employee of the Florida East Coast Railway, and Conrad Schmidt, a restaurant owner. Dances, card parties and other benefits were staged, the proceeds of which were turned over to the Association. On May 29, 1909, the Association purchased from Phillip and Jeanie Ullendorf two lots for the sum of $2,500.[4] These lots provided a square of land with 150 feet on Biscayne Boulevard at the corner of what is now N.E. Eighth Street. Soon thereafter a small frame building known as the Friendly Society Hospital was erected on this site.* Dr. E. K. Jaudon was made physician-in-chief and Miss Willie May (Mrs. Lawrence Kitrick) was appointed matron.

From the day the hospital opened it was filled to overflowing and it rapidly slipped into debt. A Ladies Hospital Aid Society was organized and staged tag days, dances, card parties, concerts, rummage sales and street corner solicitation "dressed in the fetching garb of the hospital nurse, white aprons and caps, red crosses and all," in an effort to stave off financial disaster.

As the debts mounted, conflicts arose between the board of management and the Ladies Hospital

*Despite a diligent search I have been unable to find a newspaper account of the opening of the Friendly Society Hospital. It appears to have been in operation by November 1909.



Fig. 1.—The City Hospital—1913

Aid Society. The ladies pointed out that they had raised money for an operating room but as yet none had been constructed. They insisted that one of their number should be on the board of management. This demand was rejected because "the present nurse in charge of the hospital had said that if there were any women on the board she would resign." This infuriated the ladies still more and they insisted that one or more physicians be placed on the board of management as up to that time no patient could be admitted to the hospital without the approval of the board of management or the matron. They pointed out "that a man had been kept outside the hospital all night in a hack because the nurse and others thought he was a plain drunk, and when he was taken in he died almost immediately." Furthermore, they demanded a women's ward be maintained because a lady had been turned away with the excuse that no beds were available although one of the ladies visiting the hospital noted "that there were eight or nine men there, all up eating their meals on the porch and not a man sick in bed at the time."

Finally, burdened with an indebtedness of $874.79, the Dade County Hospital Association petitioned the Miami City Council to take over the hospital. The transfer was effected on June 12, 1911, and the name changed to "The City Hospital." Dr. John L. North, the city physician, was appointed physician-in-charge at a salary of $90 a month and Miss Willie May was retained as matron at a salary of $75 a month. The City Council at the same time decreed that patients could be admitted only upon the certification of a physician and that all private patients be charged a minimum of $2 a day.

Shortly after the transfer an operating room was added but at first conditions were rather primitive. For example, initially surgical instruments were sterilized on the back porch in a large brass laundry boiler heated by a kerosene stove.

At this period of its existence, Miss Nash (Mrs. B. E. Hearn), who was superintendent from 1913 until June 1916, recalls a frame building providing two wards of eight beds each, two private rooms with one bed each, a kitchen, a dining room, two toilets with both a lavatory and a bath tub, a room for the supervisor with a private bath and the operating room of concrete block construction that extended toward Bayshore Drive (fig. 1). The staff of the hospital consisted of a superintendent, a night nurse, a Negro maid, a cook and an orderly. One of the most valuable members of the staff was the orderly, George Atherton, a Princeton man and a licensed lawyer who had worked as a nurse at the Massachusetts General Hospital for some years. Both medical and surgical cases were admitted. Miss Nash recalls cases of typhoid fever, malaria, pneumonia, insanity, strokes, cancer, occasional deliveries, accident victims, hysterectomies, appendectomies, herniorrhaphies, tonsillectomies, cataract extractions and amputations. Anesthesia was usually drop ether or chloroform though ethyl chloride and local cocaine were sometimes used. The patients paid $17.50 per week for bed and board to which was added a $5 charge for minor surgery and a $10 charge for major surgery. Usually the anesthetic, given by a physician or nurse, cost $5. Private duty nurses received $3 a day for which they usually worked a 24 hour day.

As the years passed the hospital became inadequate to meet the needs of the growing city, and the building began to deteriorate. The city fathers set about to replace it with a more adequate plant. There were those who wanted to rebuild on the Bayshore Drive (Biscayne Boulevard) site; however, the City Board of Health (Dr. James M. Jackson, Dr. E. K. Jaudon and Mr. Henry Ralston) favored the present day site then owned by the city and partially used as a dump. There were those who said it was "way out in the country," but Mr. E. C. Romfh envisioned Miami would some day grow to 100,000 and the hospital would then be "in town" The Dade County Medical Association supported the City Board of Health and after some heated discussions of the

City Council, architects were invited to submit plans. The plan of Mr. August Geiger was accepted on December 20, 1915. Construction on the new $150,000 hospital began sometime after August 7, 1916. World War I resulted in increased costs, material shortages and a scarcity of skilled craftsmen. Thus, when the buildings were finally completed, there were insufficient funds to provide the plumbing connections. At the request of Mr. Edward Romfh and Mr. E. G. Sewall, Mr. Edward R. Lindabury, the commanding officer at the Chapman Field Army Gunnery Station, released civilian personnel and loaned payroll money to permit this hookup. The furnishings were supplied by the local lodges of the Elks, Masons, Knights of Columbus and other organizations.

Finally, all was in readiness and on or about June 25, 1918, the patients were moved from the City Hospital on Bayshore Drive to the new site (fig. 2). A newspaper account of the hospital at that time reads as follows: "It is tinted in buff colored stucco with plastic ornaments that harmonize with the Spanish treatment of the exterior. . . . The administration building is a three story structure. The first floor will contain consulting rooms, business offices, operating rooms for minor operations, and rest rooms. On the second floor are rooms for white patients, but it is later planned to use this part of the building as a nurses' home. The third floor is to be used for storage purposes. The dormitories for white patients are in the wing to the west adjoining the service building which contains the kitchen and dining room. Wide enclosed verandahs emphasize the Spanish treatment in the architecture and will furnish a lounging place for convalescents."[5] To be noted is the lack of mention of an operating room for major operations. Apparently this was not in the original plans and shortly after the hospital opened a frame building was added just north of the east-west corridor which served as the major operating room until 1922 when a concrete block structure was built. Dr. C. F. Sayles is recalled operating in this frame building with an ice bag tied on the back of his neck to relieve the sweltering heat. In those days there were so few nurses that Dr. John B. Seeds recalled doing a tonsillectomy at 7:30 A.M. and returning at four in the afternoon to discover that no one had been in to see the patient since the operation.



Fig. 2.—The City Hospital—1918

The new hospital opened in the midst of the great influenza epidemic. It was crowded from the start, the daily census often as many as 100. A second building of frame construction was therefore erected north of the administration building to provide more beds. This ward initially accommodated 26 beds and throughout the flu epidemic was restricted to service personnel. Later it was converted into a Negro ward, and in 1925 it became the first emergency room of the hospital. So many of the hospital personnel came down with the flu that Mrs. Edward C. Romfh and other ladies of the city prepared food and soup in their own kitchens and sent it to the hospital by motor car. Therapy of the flu in those days consisted of ammonium chloride, Nux vomica, aspirin and caffeine. Some of the Navy doctors used Jamaica ginger and wrapped their patients in blankets to produce a sweat. Other doctors used ice water baths, aspirin and ginger ale.

The first nurses training school in Miami began about September 1916 at the City Hospital on Bayshore Drive. The initial class consisted of six nursing students who lived in a separate building behind the hospital. A student in that class, Mrs. D. E. (Esther Burden) Murden, recalls receiving a cap after several months. This nursing school limped along, however, and did not become vigorous even after reorganization and incorporation on January 8, 1919. Miss Ainah Royce who arrived in the winter of 1920 reorganized it again to form the present nursing school which graduated its first class, four students, in 1923.

When Ainah Royce arrived she tells us she caught a jitney (a large open sedan with a piece of oil cloth hanging over the left front door on which a fare of 5¢ was indicated) at the post office (First Avenue and First Street, N.E.) and the driver took her over a dirt road full of mud-

holes and rocks, right through colored town, past wooden shacks and woods, then to her surprise, "We pulled up in front of these two very nice modern buildings." On the day of her arrival the total bed capacity of the hospital was 31 beds but there were 55 patients in the hospital. Four nurses and one resident physician, Dr. Scott Fay, were caring for the patients.

Dr. A. F. Kaspar, a dentist, took the first x-rays at the City Hospital about 1919. Dr. Kaspar owned a large Edwards machine which he would "take on house calls" with the aid of the Withers Transfer and Storage truck for a fee of $5. At the request of Dr. J. D. Stuart he brought this machine to the porch of the City Hospital to x-ray a patient with a fractured leg. It was in 1922 that the hospital acquired its first x-ray equipment, a Snook machine of very temperamental character.

The first organization of the medical staff of the City Hospital occurred in 1921 with Dr. James M. Jackson the first president. Prior to this, Dr. J. L. North had been physician-in-chief and two physicians and two surgeons rotated the respective services between them every six months. The surgeons had to bring their own instruments and supplies when they performed major operations, though the hospital provided instruments for minor surgery.

Between the years 1920 and 1925 the hospital grew in services and facilities. A private pavillion, a maternity ward and isolation building, a permanent operating room, laundry and boiler house and a nurses home were completed. The first clinical laboratory was opened in 1922. Such progress was not without its problems, however, some of which were the smoke from the incinerator, the myriads of flies and mosquitoes and the constant blasting in the rock pit near the hospital. Miss Royce noted that with every blast the whole hospital would rock. Pushed to the limit of her endurance, "Miss Royce in her crisp white uniform would go over and stand on the edge of the pit. . . . She would call down to the workmen, 'You put in smaller blasts or I'll call the county commission.' "[6]

By the year 1924 the hospital had grown to 107 beds and during the year 1923-24 had taken care of 2,147 inpatients and 492 outpatients. The total operating cost for the year had been $159,857.56 of which the tax payers paid $63,300. The average cost per patient day was $5.50 with an average daily census of 66.5 patients.

On April 2, 1924, Dr. James M. Jackson, Miami's pioneer physician, died after a long illness. He had come to Miami in 1896, two weeks before the first railroad reached Miami. For many years he was the city physician and he organized the City Board of Health. So beloved was he, that on the day of his funeral, April 4, 1924, all business establishments closed and many displayed Dr. Jackson's portrait draped in mourning. On April 8, 1924, at a called meeting, the City Commission voted to change the name of the City Hospital to The James M. Jackson Memorial Hospital (fig. 3).

The year 1925 is remembered for the real estate boom when, with the help of the "Binder Boys," people became immensely wealthy on paper overnight. Land values skyrocketed and construction reached a feverish pitch. People flocked to Miami and the patient load at Jackson increased from an average of 66 to 116 per day. Its bed capacity was increased to 200 beds and the hospital boasted "two main operating rooms and one for emergencies." The nursing staff was composed of 32 graduate nurses and 35 girls in training. "Incidentally, all the nurses with only one or two exceptions, have bobbed their hair. Miss Royce voiced pleasure that there had never been any trouble in this regard as had occurred in several northern hospitals." Despite the affluence of the times about a third of the patients could not pay their way.

On Friday, September 17, 1926, the newspapers noted that a tropical storm was approaching the Florida seaboard and that "precautions should be taken against destructive winds Friday night and Saturday morning from Jupiter to Miami." It was thought that there would be no particular harm to boats in the Miami harbor. Friday evening the wind steadily increased in velocity and it soon became evident that this was no ordinary tropical storm. Shortly after midnight the electric power lines were destroyed and the hospital was engulfed in total darkness. About 2:30 a.m., mindful of the steadily increasing wind, the wise superintendent of nurses insisted that the student nurses move from the temporary nursing home. Hardly had the last of the girls scurried from the building when it collapsed. Soon after, the smoke stack on the hospital power plant collapsed, crashing through the plant roof, injuring three workmen and cutting off the steam supply.



Fig. 3.—James M. Jackson Memorial Hospital—1925

The torrents of rain, whipped by the wind, flooded in at broken windows and under the doors until two feet of water was standing in the telephone office in the administration building. Bits of roof were torn off here and there and holes had to be bored in the floor of the Deering Ward to drain off water. About 6 a.m. the winds began to diminish and injured persons started to trickle into the hospital. About 7 a.m. the second half of the hurricane struck, ripping the roofs off three wards.

Finally, about 10 a.m., the winds laid, the sun came out and droves of injured began arriving in automobiles, trucks, ambulances and even horse-drawn wagons. By eight that evening every bed was occupied and the halls were choked with people on cots. A temporary hospital was opened at the McAllister Hotel. Several maternity cases and a "clean" surgical case were sent to Victoria Hospital which still had a completely functional surgery. At Jackson surgeons did amputations and other traumatic surgery standing in several inches of water. When the confusion had cleared, six days after the storm struck, Mayor E. C. Romfh announced the tally: 854 injured and 106 dead.[7]

In 1926, Jackson received its first major endowment, $610,000 from the Deering family. In the fall of 1925, James Deering, inventor of the McCormick-Deering reaper, died of acute appendicitis aboard the liner Paris en route from France to the United States. He had long been identified with Miami and was the builder of Villa Viscaya, now the city art museum. In his will he left the income of $500,000 to establish a ward for male patients in the name of his father, William Deering. Charles Deering added $100,000, and Roger Deering $10,000. The original Deering ward, currently the site of nuclear medicine, was 200 feet in length and housed 55 beds against "two long walls, with ample corridor room the length of the ward and sufficient space between the beds for a semblance of privacy."

By 1927 the hospital was still out in the country and the minutes of the medical staff include a motion to ask the administration to fence around the surgical pavillion to prevent cows from grazing under the windows of the operating room. There had been several instances of postoperative tetanus at that time which were thought due to cow dung so unfortunately placed. There may have been other causes for postoperative infections. For example, one of the things for the young set to do was to peer into the operating room windows to "see the action."

The year 1929 brought accreditation for internship by the American Medical Association. At that time the house staff consisted of two residents and eight interns and the bed capacity was approximately 250. The cost per patient day was $4.98. The hospital laboratory was active and a note is made that "routine urine and blood examinations are made together with more complicated tests such as Kahns, blood sugars and chemistries. All tissues removed during operation are examined and numerous autopsies performed to further medical knowledge."

The first mention of an obstetrical delivery room appears in the Jacksonian Syndrome of 1929 with the statement, "It is modernly equipped with two delivery tables, six instrument sets, and gas

and ether machines for the administration of anesthetics. . . . Connected with the delivery room are the doctor's scrub rooms and the sterilizing room where all material is sterilized before using." This was located on the second floor of the building currently known as "East Wing." Although the obstetrical department was advanced to the extent of a separate delivery room, the patients in maternity cases and medical cases were kept in adjacent rooms or beds.

In 1931 the Negro patients, who had been previously housed in the "Green Houses," were moved into the main hospital. The Green Houses, so named because they were painted green, were frame buildings located north and east of the present Royce Building. They had been constructed to house the victims of a smallpox epidemic and had later served as tuberculosis wards, then a Negro hospital. Overcrowding was routine in the Negro hospital as facilities were limited. Obstetrical deliveries were accomplished on the ward in the patient's bed with what privacy a folding screen would afford. Often it was necessary to put the babies under the mother's bed in order to have walking space between the beds.

On a cool February evening in 1933, the resident on duty in the emergency room heard the screaming of sirens and the squeal of brakes. The orderly went through the swinging doors and, when he didn't return promptly, the medical resident went out to see what the commotion was about. There in the rear seat of an open sedan sat two men, one badly wounded, his shirt covered with blood. The orderly, struggling to get the wounded man out of the car, curtly ordered the other man to move his legs so that the wounded man could be removed. The other man apologized saying, "I'm sorry, but I cannot move my legs." The other man was Franklin Delano Roosevelt, the President of the United States, who had been crippled with polio as a young man. In Bayfront Park, Mr. Roosevelt, having addressed a political rally, had motioned his close friend, Mayor Anton Cermak of Chicago, to his automobile for a friendly chat. Guiseppe Zangara, a deranged, unemployed Italian bricklayer with an intense hatred for the rich and powerful, fired several bullets at the President but missed, hitting Cermak.

Mayor Cermak was immediately taken to surgery and the wound probed seeking the bullet. Subsequently he was hospitalized at Jackson for 30 days, but despite tremendous effort he died. Jackson got nationwide publicity from this incident and a Barach-Thurston Oxygen Room which was sent from Chicago to ease Cermak's distress. This rubberized cloth tent was large enough to include a bed, a small bedside stand and a chair for the nurse. It consumed huge quantities of oxygen daily and was so cold that the nurses who attended Cermak had to wear fur coats. Oxygen had been administered by face mask at Jackson as early as 1925, and primitive oxygen tents were in use there by 1931 or 1932.

Jackson continued to grow with the addition of a new surgery constructed at the height of the depression from "salvaged" concrete blocks, and the Woodard Building, financed largely from federal funds. The latter was named for the superintendent of the hospital, Dr. R. C. Woodard, whose almost single-handed efforts obtained the financing for it. Also a physiotherapy department, a tumor clinic, a medical library with a trained medical librarian, Miss Zula Morris, and an increased variety of outpatient clinics were added. When Alice Isabel Mustard joined the Jackson staff in December 1935 she was the first "general duty nurse" in the hospital. Prior to her arrival each floor had a nursing supervisor and several student nurses who did all the nursing. Miss Mustard was the first graduate nurse hired primarily to give patients nursing care. On July 5, 1938, Jackson obtained its first full time pathologist, Dr. Philipp Rezek, a renowned internist of Vienna who had left Austria after the Nazis moved in and had arrived in this country with little more than the clothes on his back. When he was appointed, the morgue was an old converted shed located where the present laundry stands. The medical laboratory, of which he was also supervisor, was in the area now occupied by medical school offices and above the electroencephalographic laboratory. Dr. Rezek served until his retirement on April 1, 1963.

Blood transfusions had been performed in Dade County as early as 1922.[8] During the 1920's, blood was matched without typing by trying the donor's cells against the recipient's serum and vice versa. If hemolysis or extensive clumping were not obtained the blood was thought suitable. Although some of the transfusions were direct, the donor lying alongside the recipient and blood be-

ing withdrawn in large syringes and injected into the vein of the recipient, the indirect method was also in use. The indirect method consisted of "withdrawing the blood from the donor in the operating room, collecting it in a flask to which an anticoagulant of sodium citrate has been added, and administering it to the patient in his own room . . ."[9] By 1940, "In Jackson Memorial Hospital an average of 150 indirect blood transfusions are administered each month and frequently as many as eight or ten a day. In order to obtain this amount of compatible blood as many as fifty or more prospective donors each day must be examined and their blood typed. The commotion occasioned by the handling of large numbers of donors, the expense of numerous laboratory blood typing tests to eliminate incompatible donors, and the costly delay in obtaining blood for a critical patient has made the establishment of a bank of prime importance." In September 1940, the Veterans of Foreign Wars volunteered to sponsor a blood bank at Jackson. This project was not implemented, however, until Mr. A. J. Cleary brought together a group of citizens representing 35 organizations and chartered the Blood Bank of Dade County on March 26, 1941. The building (the present hospital pharmacy) and equipment were obtained through the donations of the labor unions and many private firms in the county. This bank, later moved to its present location, is today known as The John Elliott Blood Bank, after its illustrious director, Dr. John Elliott.

In the early 1940's there was much squabbling about Jackson. People living within the city limits of Miami had to pay both city and county taxes and thus supported the Jackson Memorial Hospital and the Kendall Hospital. Since Jackson was available to them, however, they were not admitted to Kendall Hospital. About one third of the patients admitted to Jackson came from the county and thus paid no city taxes toward Jackson's upkeep. Then too, there were charges of inefficiency and corruption in the management of the hospital. As early as September 1940, the mayor of Miami offered to lease the Jackson to the county for $1 per year. This offer was not accepted because the county was unwilling to shoulder the expense involved. A series of administrators came and went, usually departing with angry charges of political interference in the management of the hospital.



Fig. 4.—James M. Jackson Memorial Hospital—1946

In the spring of 1941 it was proposed that a new 500 bed hospital be erected on the armory tract at N.W. Seventh Avenue and 28th Street. This was to be financed jointly by the federal government, the city and the county, and to be under the management of the county. Although President Roosevelt authorized $300,000 toward this project and a nurses home was built on the corner of Tenth Avenue and N.W. 28th Street, the difficulty in getting structural steel and other building material torpedoed this project. The nursing home which was known as "Jackson Hall" is now a part of the youth center. Although a totally new hospital could not be built, it was possible to get a loan from the federal government that was applied to the building of the Skaggs Building which was dedicated on April 8, 1946, and named after Dr. P. T. Skaggs, another of Miami's outstanding early physicians (fig. 4).

Although the town had "caught up" with the hospital by 1947, the country had not entirely left it. In August of that year Miami was deluged by rains that left water standing three and four feet deep in low areas. One evening as the 3 to 11 p.m. shift of student nurses waited at the bus stop behind the hospital, a five foot alligator lumbered up. The hero of the evening was a surgical resident, now a prominent surgeon of Miami, who "captured" the monster and trussed him up with a piece of sashcord. It was thought the "gator" had made his way from nearby Wagner Creek (12th Avenue at that time was not cut through from North River Drive to 20th Street) through the standing water to the garbage cans near the nurses' bus stop.

The struggle to get a medical school in Dade County began in the legislative session of 1943 with a bill sponsored by Senator Amos Lewis of Marianna to build a University of South Florida with colleges of medicine, dentistry and pharmacy in Dade County. The bill passed but the necessary $2 million was not appropriated. As early as July 1945, efforts were made to turn the operation of the Jackson Memorial Hospital over to the University of Miami with the hope that a medical school could be started. This idea collapsed when the county commission refused to pay the cost of caring for county charity patients in such an arrangement. In the 1945 legislative session, attempts were made to get a medical school in Tampa and Jacksonville, but again no funds were appropriated. An effort was again made in 1947 by the Dade delegation and again although passed by the Senate, the bill was defeated in the House Appropriations Committee. Finally, the legislature of 1951 voted to subsidize the first accredited medical school to be opened in the state.[10] With this backing, the University of Miami opened its doors to medical students on September 22, 1952 with a class of 26. These were the first medical students to study in Florida since 1886.

Despite bickering and political maneuvering, the work of the hospital went on. In the spring of 1946 a severe epidemic of poliomyelitis caused crowding of the hospital. An isolation ward was set up early in March and three such wards were in operation by the latter part of July. The average daily census of polio patients from May until July 23 was 50 and the hospital by that time owned three iron lungs and had borrowed five others. As the summer wore on the epidemic abated, the last active case being admitted on August 13.

As always, money matters dogged the hospital. Room rates in early 1947 were $9-$14 daily while the per diem cost of patient care was $12.85. But more than the daily operating expenses, the hospital needed capital for improvements. The County Commission agreed to put a hospital improvement bond issue to the voters if the city would transfer the operation of the hospital to the county with no strings attached. After much bickering, the City Commission finally agreed to do so in mid-June 1948, and the transfer was to be effective January 1, 1949. A bond issue of $2.5 million was approved that fall by the voters of Dade County.

January first rolled around and the county commissioners went out to see what they had acquired. They were appalled at the degree of deterioration and immediately authorized $30,000 worth of repairs to the roof. One of the county commissioners declared, "How in the name of God public property can deteriorate into such a condition is beyond me." They found the roof leaked so badly that the plaster had fallen in large squares, the lobby needed repainting, the stair wells and corridors needed repair and repainting, two elevators were out of operation, the asphalt tile floors and baseboards were in such bad condition they couldn't be kept clean, windows needed recalking, outside doors needed repainting and parts of the hospital required new electrical wiring or removal of temporary wiring. With the $2.5 million bond issue, construction and remodelling were begun in 1951. Another $4.5 million bond issue approved in November 1950, together with $1,263,500 in federal grants, furthered the program and resulted in the construction of 10 new buildings and extensive modernization of the old buildings. Among the new buildings was the first unit of the University of Miami School of Medicine, the Outpatient Clinic Building. Another $6 million hospital bond issue, approved in November 1956, allowed further expansion to bring the hospital to its present size (fig. 5).

Again, while the hospital administrator, public officials and voters struggled to improve the hospital plant, the medical staff struggled constantly to make available the newer advances in medicine. Thus, in January 1952, Dr. Robert Glover, clinical professor of surgery at Hahnemann Medical School in Philadelphia, visited Miami and assisted a team of surgeons in this area in doing mitral commissurotomies on seven patients using the finger-fracture technique. In March 1956, Dr. Robert S. Litwak, then chief of the thoracic surgery service, together with a team of thoracic surgeons, performed the first open heart operation in Florida, and possibly the first south of Baltimore. A patient with the tetralogy of Fallot was placed on a heart-lung pump, his heart opened and the defects repaired. Today at least five operations are done weekly on "the pump."

On October 1, 1959, the first cobalt teletherapy unit was put into operation. It emitted a radiation

equal to a 3 million volt x-ray therapy unit. A liquid oxygen system also was installed to pipe oxygen throughout the hospital. In early 1960 the hospital obtained its first artificial kidney, a Kolff Twin Coil type. Also in 1960, the second biplane cineradiographic equipment in the United States was installed in the cardiac catheterization laboratory.

Just as back in '98 the happenings on the island to the south of us caused an influx of people into Miami, the miseries occasioned by the government of Fidel Castro have launched a steady stream of Cuban refugees to our shores beginning in 1959. The great majority of these came to Miami and have remained there. Although the federal government set up an outpatient clinic staffed by Cuban refugee physicians, those refugees who require hospitalization are hospitalized chiefly at Jackson. In the past year and a half, with the phasing out of this outpatient facility, more and more of the exiles have been coming to the Jackson outpatient clinic. The influx of the refugees not only has crowded the hospital and increased the number of staff patients as compared to private patients in the hospital, but also has added to the budgetary deficit of the hospital. The federal government has paid only a portion of the cost of caring for these exiles. The remainder has had to be absorbed by the taxpayers of Dade County. Thus, in 1962 the United States Government paid about 58% of the cost of caring for the refugees. During the year 1961-62, almost 22,000 Cuban refugees received inpatient or outpatient treatment at Jackson. The number has continued to grow until during the year 1965-66 approximately 24,000 inpatient days were logged by Cuban refugees and approximately 14,000 outpatient visits. Not all has been on the debit side of the ledger, for among these refugees have come some outstanding physicians who have made inter-



Fig. 5.—The University of Miami-James M. Jackson Memorial Medical Center—1965

Table 1.—Administrators of the Jackson Memorial Hospital and its Predecessors

Eugene K. Jaudon, M.D.	1909 (? July)-1911 (June) (Friendly Society Hospital)
John L. North, M.D.	1911 (June)-1920 (The City Hospital)
Ainah Royce, R.N.	1920-1924
John F. Bresnahan, M.D.	1924 (Mar.)-1925 (Nov.)
Ainah Royce, R.N.	1925 (Nov.)-1926 (Mar.)
Alexander McRae, M.D.	1926 (Mar.)-1931 (Nov.)
Robert Crawford Woodard, M.D.	1931 (Nov.)-1940 (Apr.)
Charles L. Clay, M.D.	1940 (Apr.)-1943 (Oct.)
Executive Committee—Scheffel H. Wright, M.D., Chairman	1943 (Oct.)-1944 (Apr.)
Hart E. Van Riper, M.D.	1944 (Apr.)-1945 (June)
Charles C. Hedges, M.D.	1945 (Oct.)-1946 (Jan.)
R. Zack Thomas Jr.	1946 (Jan.-Aug.)
Charles C. Hillman, M.D.	1946 (Oct.)-1955 (Aug.)
Kermit H. Gates, M.D.	1955 (Aug.)-1965 (Aug.)
Charles William Nordwall	1965 (Aug.)-Present

nationally renowned contributions to medicine and who are serving the hospital and medical school brilliantly. Also among the refugees are nurses and other personnel whose efforts have been of great benefit to our medical community. The hospital and the city have become clearly bilingual, which adds charm to its culture.

Which way the future? On February 9, 1965, the Metropolitan Dade County Commission and the trustees of the University of Miami entered into an agreement to create a large metropolitan medical center to be known as the University of Miami—James M. Jackson Memorial Medical Center. Pursuant to this agreement, in October 1966, a joint planning committee unveiled a 20 year plan for the development of a 500 acre health center. The nucleus will be the James M. Jackson Memorial Hospital which now numbers 1,244 beds in 34 buildings totalling over 1,250,000 square feet of floor space (fig. 5).

The first buildings of the medical school, the Outpatient Clinic, the Medical Research Building, and the Bascom Palmer Eye Institute have been in operation for some time. The Basic Science Building is now under construction and will be completed at a cost of $9 million. The funds are in hand for the construction of a medical library at a cost of $1.6 million and ground breaking is anticipated in the immediate future.

This campus now accommodates 300 medical students, 300 interns and resident physicians, 100 postdoctoral fellows, 400 nursing students and 100 paramedical personnel in training.

At the present time the medical community includes the Veterans Administration Hospital which is about to open its doors, the Cedars of Lebanon Hospital, the Dade County Public Health Department, outpatient facilities of various types and an office building for private physicians. Scheduled for construction in the immediate future are a facility for retarded children, a state mental health institute and possibly a branch of Dade Junior College devoted to the training of paramedical personnel.

What of the future? We anticipate that with sound planning and energetic support Miami will develop the Inter-American Medical Center of the future. This center will be a fitting tribute to the memory of the pioneers and the people of Dade County whose vision, determination and support made the Jackson Memorial Hospital a reality.

The author wishes to express his gratitude to the many physicians, nurses and others who have aided and encouraged this project. Particular thanks are due Miss Alice Isabel Mustard, for many years Director of Nurses at Jackson, and an energetic student of the history of the Jackson Memorial Hospital.

References

1. The Miami Metropolis, August 11, 1899, p. 7.
2. The Daily Miami Metropolis, April 28, 1904, p. 1.
3. Gramling, John C.: History of Dade County Hospital, an address, delivered at the unveiling of a plaque at Jackson Memorial Hospital, October 11, 1937, p. 2.
4. Dade County Deed Book 47, p. 76.
5. "City Hospital May Be Opened During The Week," The Miami Daily Metropolis, June 18, 1918, p. 1.
6. Voltz, Jean: "Supervising Hospital Here In 1920 Was Difficult Job," The Miami Herald, April 26, 1953, p. 13-F.
7. Romfh, E. C.: "Official Storm Statement by Mayor E. C. Romfh," The Miamian, VII: September-October, 1926, p. 10.
8. Snyder, Clifford C.: "Blood Is Gold, Part II," The Bulletin, Dade County Medical Association, May, 1958, p. 32.
9. Jones, E. V. W.: "Miami War Vets Give Blood Bank," The Miami Herald, September 15, 1940.
10. The Miami Daily News, September 5, 1951, as reprinted in Jackson Memorial Record I: September 7, 1951, p. 1.

▶ Dr. Straight, 245 S.E. First Street, Miami 33131.



This daguerreotype, made in the 1850's, is thought to be the only authentic likeness of Dr. John Gorrie. The most complete collections of information about Dr. Gorrie may be found at the P. K. Yonge Historical Branch of the University of Florida Library, Gainesville, and the Dr. John Gorrie Historical Memorial, Appalachicola.

John Gorrie, M.D.

A Man Ahead of His Time

Edward Jelks, M.D.

The work of few persons has added so vitally to the preservation of food products, personal comfort and the attraction of mankind to the warmer sections of our planet as has that of Dr. John Gorrie. Today, manufactured ice, refrigeration and air conditioning are routine items of our way of life. When and how they were conceived are of special interest to physicians in Florida since Dr. John Gorrie, while practicing medicine in Apalachicola, introduced the procedures which brought them into existence. His objective was to make operative methods to fight fevers destructive to health and sometimes to life.

For centuries it was observed that certain fevers occurred where people lived near swampy areas. The distinguished "father of architecture" Vitruvius almost two thousand years ago, in selecting the site for a city, wrote: "Such a site will be high, neither misty or frosty, and in a climate neither hot or cold; further, without marshes in the neighborhood. For when morning breezes blow toward the town at sunrise, if they bring with them mists from the marshes, and mingled with mists, the poisonous breath of the creatures of the marshes to be wafted into the bodies of the inhabitants, they will make the site unhealthy." Mankind followed this theory of the origin and spread of certain fevers for several decades after the death of Dr. Gorrie when the connection of mosquitoes with the true method of the spread of these fevers was proven.

Working on the theory that in the marshes, through an unexplained process of decomposition of organic matter, a poisonous volatile oil was formed, Dr. Gorrie concluded that to prevent "swamp fever" (chief of which was malaria):

1. Swamps should be drained where organic matter could decompose and produce poisonous volatile gases.
2. Moisture, which is necessary for the spread of the gases, should be reduced.
3. Temperatures should be moderate, especially not too hot, in order that the poisonous gases not be created.

With these ideas in mind, Dr. Gorrie advocated first draining neighboring marshes, and second, creating an environment of lowered moisture and temperatures. These two advantages of lowered moisture and temperature, he recognized,

could be attained by artificially conditioning the air. This necessitated a reliable supply of ice.

On July 14, 1850, for the first time in history, artificially made ice was used at a public meal. It was used to cool wines at the old Mansion House in Appalachicola for guests gathered to celebrate Bastile Day. Dr. Gorrie had been working for over 10 years to devise a machine which could produce ice. It was based on the principle that gases, when permitted to expand quickly, absorbed heat from substances about them. His machine, for which he obtained a U. S. patent in 1850, consisted of a pump which increased the pressure of air in a chamber; within the chamber was placed a container filled with water that would freeze when the gas in the chamber was permitted to expand rapidly.

Once a supply of ice could be assured, the next step was to use it to lower the temperature in a limited area in order to provide a cool environment with lowered humidity in which a person would be protected from fevers resulting from "bad air" (malaria). Dr. Gorrie's plan was to use a room without the usual openings of windows and doors. At the floor level in one wall there was to be an opening and from the ceiling in one corner there was to be hung a bowl containing a block of ice. Over this block of ice was to be placed a cone-shaped hood connected to a pipe which passed through the ceiling into the chimney. With this arrangement it was expected that the cold air from the melting ice would descend and pass out through the floor-level opening. When this took place there would naturally be a suction of air through the vent pipe which would draw air over the ice and cool it. The air, before entering the vent pipe, would pass through the chimney where the soot carbon, acting as a filter, would withdraw some of the impurities in the air. Such a circulation of air which had been cooled, passing continuously in from above and out below, would reduce the room temperature and diminish the humidity. The processes of present day air conditioning are based on principles similar to those recognized by Dr. Gorrie more than a hundred years ago. It is interesting to remember that early in this century many moving picture theaters were "air conditioned" by having an electric fan blow air over a block of ice raised above the audience, rather than the present practice of cooling air by passing it through a mechanically chilled "cooler."

In 1929 it was my good fortune to visit Mrs. Carrie Floyd Stewart, Dr. Gorrie's granddaughter in Milton, Florida. She stated that although there was information regarding Dr. Gorrie and his work in publications such as medical journals, newspapers and the government patent department records, the best sources of information about Dr. Gorrie were lost when his entire library, manuscripts, drawings and working model of his ice machine were destroyed by fire during the War Between the States. Mrs. Stewart stated that Dr. Gorrie was born October 3, 1803, spent his childhood and years of early education in Charleston, South Carolina and gained his medical education in the College of Physicians and Surgeons of the Western District of New York at Fairfield in Herkimer County. It is thought that upon graduation in 1827, he probably began practice in Abbeville, South Carolina. At any rate, it is agreed that he arrived at Apalachicola in 1833 where he remained until his death in 1855. During these 22 years he was active in the life of the community. He was a member of the board of directors of several business organizations and also served the city as its mayor. All the while he was engaged actively in the practice of medicine with emphasis on programs that could help eliminate fevers which, especially in the hot summer weather, caused so much distress.

After Dr. Gorrie had produced artificial ice and introduced it to the public in 1850, his five remaining years were devoted to the problems of promoting development of the ice industry. Progress along this line was so slow that it was several decades after his death in 1855 that the general use of artificial ice came into being. Air conditioning as we know it today was even slower in being developed.

In 1924, the State of Florida, to honor her illustrious son, Dr. John Gorrie, placed in Statuary Hall, Washington, D. C., his statue, made by Mr. Adrian Pillars, the well-known Florida sculptor. The statue bears the inscription "October 3, 1803-June 16, 1855," Dr. Gorrie's life span. We physicians are proud that our state, when allowed to honor only two of its distinguished citizens in such an outstanding manner, chose one from the profession of Doctor of Medicine, and one who contributed marvelously to man's comfort and well-being.

▶ Dr. Jelks, 2244 St. Johns Avenue, Jacksonville 32204.

Practice of Pathology in Florida 1908-1941

Alvan G. Foraker, M.D. and Lucien Y. Dyrenforth, M. D.

This essay will comment on the early days of the practice of pathology in Florida. In general, our comments will emphasize the time prior to World War II, except for brief notes on the first pathologists in certain areas. The various regions will be noted geographically.

One of the first pathologists in the Miami area was Dr. Iva C. Youmans[1,2] who graduated from Johns Hopkins University in 1909. From 1910-1917, she served in the Florida State Board of Health laboratories in Jacksonville with Dr. Henry Hanson. She was the only woman graduate in medicine in the state when she entered practice. In 1917, she went to Miami to establish a branch laboratory of the State Board of Health. She also opened a private laboratory there. Dr. Youmans returned to the Jacksonville area for some years, where she worked at Riverside Hospital as a pathologist, as well as giving anesthetics and performing various clinical duties. She returned to Miami, however, and resumed her private laboratory practice. Dr. Youmans also had pathology responsibilities in Jackson Memorial Hospital, where she was in charge of the first obstetrical ward. She practiced pathology in various hospitals in the Miami area over the years, while continuing some general practice. Her laboratory served physicians in the Bahamas and British Honduras as well as in the Miami area. Dr. Youmans retired from practice at age 77 and lives in Miami. Dr. Philipp Rezek came to Jackson Memorial Hospital in Miami in 1938.[3-5]

Prior to 1931,[5] Dr. V. M. Jared was a pathologist in West Palm Beach. Dr. V. Marklin Johnson, a native of Key West and graduate of Tulane University, began practice in West Palm Beach in 1931, and during the ensuing years was the only pathologist there prior to World War II. He continues in practice there.

The early history of pathology in Southwest Florida is the story of Dr. Herbert R. Mills of Tampa.[6] Dr. Mills[3] graduated from Rush Medical College, Chicago, in 1910. He came to Florida that year and was in charge of the Florida State Board of Health laboratory in Tampa. He volunteered in World War I and served with the British Army, and later with the U.S. Army of Occupation in Germany. On his return, he became pathologist at the Bayside Hospital, and later at the Tampa General Hospital. Dr. Mills also served as pathologist to St. Joseph's, Centro Asturiano and Centro Espanol hospitals. He received tissues from Fort Myers, Sarasota, St. Petersburg and adjacent areas until pathologists settled locally. In 1928 he opened a private laboratory in Tampa which he maintained until his death in June 1952. Most of the older pathologists in Southwest Florida[6] at one time or another worked with Dr. Mills, including Dr. James B. Leonard of Clearwater, Dr. Millard B. White of Sarasota and Dr. Ira C. Evans of St. Petersburg. Dr. Mills' partner was Dr. James N. Patterson,[3] a graduate of the University of Cincinnati, who came to Jacksonville in February 1938 to become director of the Bureau of Laboratories of the

Florida State Board of Health. Following military service in World War II, he entered into practice in Tampa with Dr. Mills in 1946, where he continues.

The first pathologist in the Central Florida area was Dr. George R. Kerr,[7,8] who came from Nebraska to the Orange Memorial Hospital in Orlando in June 1942. Previous to that time, Dr. Horace A. Day, a surgeon who had had some training in pathology, supervised the hospital laboratory. Recently, the pathology laboratory at Orange Memorial Hospital[7] was dedicated to Dr. Day. Dr. Kerr left Orlando in 1953 and is now in practice in Burlington, North Carolina.

The first pathologist in Daytona Beach was Dr. Leon W. Lippincott[9] who arrived in 1947. Dr. Lippincott died of leukemia in November 1950, and his immediate successor was Dr. William W. Schildecker, who is still in Daytona Beach.

One of the first physicians to practice surgical pathology in Jacksonville[1] was Dr. James H. Hartman, a surgeon who came to St. Luke's Hospital in 1908. He did surgical pathology for physicians who occasionally submitted tissue specimens, and he, as well as other physicians, performed their own autopsies on occasion. Dr. Henry Hanson[10] (Johns Hopkins, 1908) came to Jacksonville in 1909 to be head of the State Board of Health laboratory. In 1916 he started a private laboratory in Jacksonville. After World War I, he was Director of Public Health for Peru until 1922, then reopened a private laboratory in Jacksonville in 1923.

Dr. William Wilson Kirk[1] opened a clinical laboratory in Jacksonville in 1918. He also headed the laboratories of the Duval County Hospital and St. Luke's Hospital. In the mid-1920's, Dr. T. Z. Cason[1] went to Chicago's Cook County Hospital, learned the current clinical chemistry technics, and established them at Riverside Hospital. In 1928, Dr. Clayton Elbert Royce of Bethlehem, Pennsylvania, was called to be the first pathologist[1] for the "new" St. Vincent's Hospital in Jacksonville. Dr. Lucien Y. Dyrenforth, a graduate of Emory University, joined him as a partner in 1931. Drs. Royce and Dyrenforth were responsible for pathology services at St. Vincent's, St. Luke's, Duval County, Hope Haven and Brewster hospitals. Their private pathology practice covered the state from Pensacola to Key West, and extended into Southeastern Georgia and Alabama. Dr. Nelson A. Murray,[11] a native of Jacksonville and a Tulane graduate, joined Dr. Royce at St. Vincent's Hospital in 1944. Dr. Royce died shortly thereafter.[1] Dr. Murray left St. Vincent's Hospital for the private practice of pathology in 1951.

There were no pathologists in Tallahassee prior to 1949[12] when Dr. Clarence W. Ketchum entered practice there, although there had been previous pathologists at the State Hospital in Chattahoochee.

Dr. William Spears Randall Jr.[13] was the first pathologist in Pensacola. He went to the Pensacola General Hospital in 1940. Dr. Randall says that to the best of his knowledge, there were no other pathologists in the West Florida area at that time. Dr. Randall left for military service in 1942, and is now in practice in Baton Rouge, Louisiana. Dr. Gretchen V. Squires[14] settled in Pensacola in 1945, where she is presently in active practice. In 1945, Dr. Squires covered pathology service from Quincy to Pensacola, including Panama City, DeFuniak Springs, Crestview, Fort Walton Beach and Milton.

References

1. Dyrenforth, L. Y.: Personal communication.
2. Youmans, I.: Personal communication.
3. Patterson, James N : Personal communication.
4. Anderson, W. A. D.: Personal communication.
5. Johnson, V. M.: Personal communication.
6. White, M. D.: Personal communication.
7. Derrick, W. A.: Personal communication.
8. Kerr, G. R : Personal communication
9. Schildecker, W. W.: Personal communication.
10. Hanson, K. B.: Personal communication.
11. Murray, N. A : Personal communication.
12. Ketchum, C. W.: Personal communication
13. Randall, W. S , Jr.: Personal communication.
14. Squires, G. V.: Personal communication.

▶ Dr. Foraker, 800 Miami Road, Jacksonville 32207.

Joseph Yates Porter, M.D.

The Merchant's Son Who Became Florida's First State Health Officer

Wilson T. Sowder, M. D.

The father of Joseph Yates Porter was a man 21 years old establishing himself as a merchant, and possibly expanding the family business enterprise from Charleston, S. C., when he visited Key West in 1838. He found the city a pleasant place and a few years later decided to make it his home. No doubt Mary Ann Randolph, daughter of Captain Thomas Mann Randolph, commandant of the U. S. Revenue Service cutter Washington, in the Port of Key West until his death from yellow fever, influenced this decision. In May, 1845—she was 18 years of age—they were married. Early in 1847 he returned to Charleston on urgent personal business. Because of a hurricane that had swept the coast, return passage was not immediately available. While waiting for a ship on which he could make the trip home, he died of yellow fever. A few months later, on October 21, their son was born. She named him Joseph Yates Porter for his father and the fathers before him back to the fifth generation.

The boy grew up in Key West guided by his mother and grandmother, Susan Eaton Randolph.

Early Years

Early in life Joseph Porter felt the fear associated with yellow fever and heard stories of this pestilence, brought into the port by ships from Havana, that eventually swept through the town with a fury greater than the storms of late summer and early fall. He saw the people of the island flee from an enemy which had been recognized in Cuba for 140 years and for about a half century had caused an average of two deaths each day there. He witnessed the preparations his mother made early each summer to leave their home and, with the help of Mrs. Randolph, to make another home in Virginia. They did not return to Key West before late fall, often waiting for the heavy frosts and first snow on the mountains, and he was too young to comprehend their explanation that the cold winds blew away the offending cause of the disease.

His mother died at 33, the year he was 13, and he became the ward of his grandmother. Growing disagreement with the North resulted in the South's decision for secession; the outcome was war. Within a short time the Confederate states began to feel the strength of the North; Florida witnessed an invading army, and troops occupied the strategic port of Key West.

The boys too young to join the Southern forces formed the Key West Volunteers and after surreptitiously training with whatever firearms they could muster the small band of soldiers marched against Fort Taylor and sent a message to the commanding officer demanding surrender. He replied that he would spank them with the flat of his sabre if there were any more impudent messages and sent them home. With their carefully planned mission a failure, the Volunteers disbanded. The Porter boy had been their leader.

Possibly because of this incident and Mrs. Randolph's strong and outspoken alignment with the South, she was ordered by the commanding officer of Fort Taylor to leave Key West. Ill Union soldiers were quartered in her home before she could get out of the city. Able to arrange

passage by boat only to the mainland, she and the boy traveled overland through the Confederate and Union lines to Cooperstown, N.Y.

Here, with war far away and victory for the South an admitted impossibility, young Porter was enrolled in school; however, after a short time he was sent to St. Mary's Hall in Burlington, N.J., which his mother had attended, then to Jefferson Medical College at Philadelphia. He pursued the study of medicine in the Key West office of Dr. William F. Cornick, a former Army surgeon, and during the summer of 1867 contracted yellow fever at the time of a severe epidemic that began at Fort Jefferson located on Garden Key in the Dry Tortugas group some 70 miles west of Key West.

A report of his illness was significant for two reasons, he stated, "first, the amount of ignorant medication the human system can stand and throw off—for I was desperately ill, and second, the fact that no one dies until his or her predestined time arrives."[1]

Years of Yellow Fever

At the time, Dr. Samuel A. Mudd was in charge of the Fort's hospital, a duty assigned to him after the death of the post surgeon from the fever. He had been imprisoned on July 24, 1865 for allegedly aiding the escape of John Wilkes Booth who, to him, had been a patient with a fractured left tibia just above the ankle that required repositioning. One of his first orders closed the hospital on Sand Key which appeared an inhuman place, for it housed only the fatally ill patients who were carried there in small boats and had to face coffins piled up in the bow.

Early in September 1867, Dr. Mudd wrote his wife: "Nearly every man now on the island is infected with the disease. The greatest consternation prevails. . . . Although three fourths of the garrison has been removed, the epidemic seems to increase with unabated fury."[2]

Dr. Mudd regained his freedom on March 8, 1869, and the following year Jefferson Medical College conferred upon Joseph Yates Porter the degree of Doctor of Medicine. Dr. Porter accepted a commission in the U. S. Marine Hospital Service as acting assistant surgeon and requested assignment to Fort Jefferson. His immediate plans included marriage on June 2 to Louise Curry of Key West, daughter of William Curry, one of the first ten millionaires in the United States whose possessions included table service made of solid gold. Initial duties involved management of yellow fever in epidemic proportions.



Joseph Yates Porter, M.D., Florida's first State Health Officer.

The Fort was familiar to Dr. Porter. Construction was begun in 1846, the year before he was born and one year after Florida became a state. It had been planned as one in the great chain of forts extending from Maine to Texas; however, during construction the walls began to crack and sink. The island was not solid rock as the original surveys indicated. The cannon in the Fort were never fired, but because of frequent epidemics it became known as one of the worst prisons and death holes anywhere in the world.

After battling yellow fever in periodic outbreaks for some three and a half years as acting assistant surgeon, Dr. Porter became assistant surgeon. His report upon the epidemic of 1875 indicated he had "carefully examined the subject and creditably performed his work."[3] Possibly due to the need for medical officers in an outbreak of yellow fever, he was detailed to Fort Ringold, a temporary frontier post on the Texas side of the Rio Grande River where the principal

concern was skirmishes with the Indians. Dr. Porter's personal satisfaction and enjoyment was clinical practice among their children. At this U. S. Army installation, he became acquainted with Dr. William C. Gorgas, a lieutenant eight years his junior born at Mobile, Ala., stationed at nearby Fort Brown, and began a mutually close and lasting friendship.

In 1880 Dr. Porter was promoted to captain. When he was slated for another promotion five years later, the physicans on the Army's medical board at San Antonio informed him, following a thorough physical examination, that he was suffering a heart condition which probably would terminate fatally within a short time. Arrangements were made for him to return to Key West by boat. For comfort, the captain placed a cot for him on deck, but Dr. Porter stated this arrangement was for the convenience of the crew if the prognosis of the medical board proved accurate.

On May 18, 1886, during the 13th Annual Meeting in the Opera House at Palatka, he was elected President of the Florida Medical Association for the ensuing year. Previously he had served as secretary and as treasurer. He also presented the paper entitled "Four Cases of Yellow Fever", written by Dr. R. D. Murray of Key West, a Past President, who was unable to attend the meeting.

Beginning of 1887 Yellow Fever Epidemic

During his term as President, yellow fever again reached epidemic proportions in Key West. Dr. Porter reported that it came into the city in an "insidious" manner either during the winter or early spring before the quarantine season commenced. A family by the name of Bolios which had operated a hotel in Havana moved into quarters above a restaurant in Key West; one of the children was ill at the time. Within a short period, the family of the owner of the restaurant, whose name was Baker, also became ill and died. The disease rapidly became epidemic.

Dr. Porter, serving as chairman of the Monroe County Board of Health, stated that the epidemic ended in early September "by segregation of the sick and destruction of fomites" and "there has not been a case of yellow fever in Key West or any suspicion of a case, notwithstanding strangers commenced to return to the Island in early October."[4] The condition sometimes was known as "strangers' disease" since those not native nor who had lived in an endemic area usually were the first victims.

Despite Dr. Porter's report, a refugee camp was established by the U. S. Marine Hospital Service on Egmont Key at the mouth of Tampa Bay as a quarantine station for the depopulation of Key West. This action created considerable controversy among physicians. They believed the people in Tampa were being unnecessarily exposed; however, the Hillsborough County Board of Health had requested the camp.

Yellow Fever in Tampa

The refugee camp and rigid quarantine measures failed to prevent the disease spreading to Tampa. Surgeon General John B. Hamilton of the U. S. Marine Hospital Service, maintaining that the first cases were kept secret from August to October, 1887, stated, "No case from Egmont communicated the disease." Dr. Porter replied that the disease could not have been transmitted from Key West by legitimate travelers. No steamer passengers to Tampa had been allowed except those "acclimated by a previous attack, and all baggage fresh laundered and disinfected and fumigated before leaving the dock for the steamer."[5] He suspected that fruit smugglers operating along the Gulf Coast had been responsible.

Shipment of fruit for an Italian, Charlie Turk, in Tampa, had been refused from Havana or Key West. Since the shipments were necessary to continue in business, he created a route overland from an unloading point in Punta Gorda Bay. Turk and at least one of the men who worked for him were known to have made frequent trips to Key West while yellow fever was epidemic there. His entire family was the first to be taken sick.

Since the disease appeared to follow railway lines, Dr. A. W. Knight of Jacksonville, secretary of the Duval County Board of Health, was sent to Tampa for an investigation. He reported no evidence of an epidemic, but that patients had died from yellow fever in Plant City.

The Florida State Protective Association, composed of one representative from each county board of health under the presidency of Dr. King Wyley of Sanford, recommended a quarantine against Tampa in December 1887. Members of the Hillsborough County Board of Health, angry

over what they considered rather stringent measures imposed against the area, maintained that the disease had disappeared. Unfortunately it had not; cases of fever lingered all winter.

Disquietude prevailed about the entire state. Dr. Porter stated that immense damage to business interests resulted from unfounded rumors and unwarranted publicity. Dr. Neal Mitchell of Jacksonville, president of the Duval County Board of Health, summarized the report by Dr. Knight and sent it to Surgeon General Hamilton requesting his advice and counsel. Inadvertently, Dr. Hamilton released the summary to the newspapers.

In the cities about the state where definite cases of fever became known, general alarm resulted and in some instances even panic. Quarantines were invoked in efforts to curb the spread of the disease. There was a lull in late fall and during the winter.

Dr. Charles J. Kenworthy of Jacksonville, city health officer, in a paper entitled "Yellow Fever Lesson" presented on May 15, 1888 at the 15th Annual Meeting of the Florida Medical Association in Gainesville, charged that the neglect of duties or inefficiency of the Key West authorities was responsible for yellow fever being brought into Florida the previous year from Havana.

Commenting[6] upon the presentation, Dr. Porter replied that Dr. Kenworthy failed to produce "after making this malignant statement, by a single instance, proof to substantiate his charges." He stated: "I was afraid when the title of the paper was announced several weeks ago, that its conception did not take place under favorable circumstances, and am, since its reading, more than confirmed in that belief by the misshapen product that the gestation has produced."

"I regret," Dr. Porter continued, "that Dr. Kenworthy has deemed it proper for him to submit this paper to the Association and then make himself conspicuous by his absence, particularly so as there are charges in the article against myself and my colleagues of the Board of Health of Monroe County which, if true, denote a carelessness that was nothing less than criminal and should be punished by the courts."

Fever Spreads to Jacksonville

Dr. Porter visited Dr. Mitchell in Jacksonville on July 28 and remained overnight with him. During the evening Dr. Mitchell was called to the Grand Union Hotel to see a patient who had been ill when he arrived from Plant City by way of Tampa. The following morning Dr. Mitchell requested Dr. Porter to examine the patient, R. D. McCormick, with another of his colleagues, Dr. Kenworthy. The findings of Dr. Porter and Dr. Kenworthy confirmed the initial diagnosis of yellow fever. This was the first definite case recorded in the city.

There was some indication that the disease had been prevalent in the city during January; however, since the suspect condition occurred principally among the well-to-do, the diagnosis was "society fever." Several physicians believed they were treating yellow fever, but their suspicions caused little concern. The illness seemed to have disappeared by spring.

On August 8, the physicians publicly reported four new cases of yellow fever and five additional ones the following day. The Duval County Board of Health announced that the disease was assuming epidemic proportions.

The pattern of fear associated with the threat of an epidemic, which Dr. Porter had recognized and reported from other sections of the state, began assuming a familiar form. The day four cases were reported, fear and anxiety gave way to panic. With announcement of five more cases and possible epidemic conditions, carriages, drays and wagons filled with people streamed toward the railroad depot and the docks. Every outgoing train and steamer was crowded beyond capacity.

Dr. Porter recalled: "Toward the middle of August, I received a call from the Duval County Board of Health to come to their professional assistance, as one of their local physicians, Dr. Baldwin,* had died and many others were sick. The Marine Hospital Service had established a camp for refugees leaving Jacksonville to spend a detection period of 10 days before being allowed further travel out of the state. Assistant Surgeon John Guiteras was in charge, but afterwards was relieved by Surgeon Hutton.

"The Marine Hospital was also aiding and assisting by payment for disinfectants and other so-called disease-suppressing measures. There arose at this time some confusion in administration of government aid, in rendering of bills and at the request of both County Boards of Health, the Auxiliary Sanitary Association and the Sur-

*Dr. W. L Baldwin, son of Dr. A. S. Baldwin.



Dr. Porter was born in this house at Key West and died here almost 80 years later. He occupied the same room throughout this period except when duties required him to be away from home.

geon General of the Marine Hospital Service, Dr. John B. Hamilton, I consented to assume charge of what was afterwards known, when attaining larger proportions, the Government Relief Service. Gradually, control of the volunteer professional aid and direction of nurses were assigned to this management."[7]

The decision was made in September to depopulate the city. The federal government provided transportation without charge to Hendersonville, N. C., one of several cities which had offered refugees temporary homes, but this plan proved impractical and camps were established near the city. A house to house canvass, conducted by the U. S. Bureau of the Census, showed that the population dropped from approximately 20,000 to about 14,000, of whom only 4,000 were white.

The peak of the epidemic appeared late that month when nearly 1,000 new cases of yellow fever and 70 deaths were reported in one week. "Most of the people were entirely without resources. Stores and residencies were deserted, business was utterly demoralized, and at night an uncanny stillness which settled over the city was broken only by the occasional rattle of a death cart. Unless it was absolutely necessary, no one went out of doors between sunset and sunrise."[8]

Dr. Porter described the time as one of "constant dread, actual fright and brutal instances of neglect where a member of a family deserted home, a sick wife and children because of uncontrollable fear. Panic is a weapon of no mean strength in inflicting injustice, and fear begotten of the panicky conditions which prevailed at that time carried an irresponsibility of action which to a rationally acting mind was difficult to understand."[9]

During the first week of October there were indications the epidemic had begun to diminish. Only 500 new cases of fever and 37 deaths were reported. The signs became definite by the last week when new cases and deaths dropped to one half the previously reported figures.

Epidemic Ends

On October 22, Dr. Porter was given the responsibility for determining when the people would be allowed to return to their homes. The official resolution sent to him by Mr. E. Higgins, recorder for the city, stated in part "that for the public good, we hereby forbid the coming of our absent fellow citizens and all others into the city of Jacksonville until announcement has been made by Dr. J. Y. Porter, government agent, that they may come with safety. That we hereby relinquish to Dr. Joseph Y. Porter, as agent of the United States Government, all our power to act on the premises at his discretion until such time as he may announce it safe for persons to come into the city."

The temperature fell to 32 degrees on the night of November 25. Dr. Porter stated that the epidemic ended the first of December. Since only a few new cases occurred during the first of the month, he and his associates decided upon December 15 as the day residents would be allowed to return to the city. On that day, several hundred came back to their homes and the local newspaper reported that the streets showed encouraging signs of life again.

Practically all activities connected with the epidemic had ceased. There was a special meeting of the Jacksonville Auxiliary Sanitary Association on Jan. 22, 1889 to hear final reports. Dr. Porter had asked both the association and the Duval County Board of Health to consent to his application to Surgeon General Hamilton requesting relief from his duties so that he could resume the active practice of his profession at his home in Key West. He had served continuously in Jacksonville for four months without compensation.

Following presentation of formal resolutions and addresses by fellow physicians and city officials, Dr. Porter reported the work of disinfection

in the city nearly complete and expressed the hope that present good sanitary conditions would be improved. Referring to the addresses, he stated: "As I have been listening here to the many pleasant words which have been spoken I felt as if I had been listening to my obituary. I am afraid that it may make me conceited. My wife thinks I am somewhat conceited now, and I have fears of her opinion on my return home."[10]

Mr. James M. Schumacher, a member of the Association's executive committee, presented Dr. Porter with an engraved gold watch, "probably the most elegant one ever brought into Florida, and the accompanying chain and charm are perfect works of art."

"The meeting then adjourned, but scores of the surgeon's admirers and friends crowded about him to express their personal thanks for his services, and to say good-by. The scene was one long to be remembered, and the whole affair was a notable one in the entire sympathy displayed by all present with the cause which had called them together."

Board of Health Formed

On Feb. 5, 1889, upon the call of newly elected Governor Francis P. Fleming, the legislature began a special session for the purpose of establishing a State Board of Health.

The previous year, a resolution had been introduced at the Annual Meeting of the Florida Medical Association in Gainesville "urging the imperative importance of organization of a State Board of Health, as ordered in the Constitution, and vesting the same with such authority and means as will give them authority to act."[11] Dr. J. Y. Hicks of Orlando, speaking as President, stated that a Board was a necessity.

In his address as President of the Association at the Annual Meeting in St. Augustine on May 17, 1887, Dr. Porter stated: "It is earnestly to be hoped for and desired that the present legislature of the State, now in session, may form a State Board of Health with powers so broad and comprehensive that nothing may be omitted which the most captious and critical of sanitists could wish for, for it is my opinion that to this organization, now about to be created, much of Florida's advancement, commercially and otherwise, is to be due.

"All the unhappy experience of the past shows conclusively that boards of health should be given almost absolute authority in their fields, for the lack of it exposes them continually to an ineffective carrying out of their plans and directions, and sometimes to personal insult and bitterness of feeling. The importance of giving our boards of health more scope and power was vigorously pointed out at our last annual meeting by the then president, Dr. Phillips. . . ."[12]

Dr. N. D. Phillips of Gainesville had declared the law establishing county boards of health wholly inadequate. "There should be a board whose jurisdiction extends over the entire State. We are liable at any time to be invaded at points where there are no local authorities to furnish either law or the money to ward off or arrest the progress of the enemy when he has once gained a footing on our soil. In such cases the State Board of Health should have the power to act at once, and should be provided with the necessary funds by the State to enable it to wage a vigorous and successful warfare upon the enemy."[13]

At the time Dr. Porter delivered his address, Dr. J. C. Pelot, chairman of the Committee on Public Health, was in Tallahassee and the State Board of Health bill had been introduced by him into the House. Dr. Porter joined Dr. Pelot and laid before Governor Edward Perry what he considered "an urgent necessity for immediate action to secure legislation for a central health department."

The bill failed to gain the necessary support, yet even then the "enemy" Dr. Phillips had spoken of the year before already had gained a footing. It had moved along the Gulf coast to Tampa, inland to Plant City and waited there to travel along the railroad to Jacksonville and Northeast Florida. Hampering travel, disrupting commerce and claiming lives, the "enemy" nevertheless served as the stimulus for a legislative action that had been sought since 1875.

Years as Health Officer

The legislature deliberated almost 15 days before passing the act creating the Board; it was approved by Governor Fleming on Feb. 20, 1889. He appointed as members Dr. R. P. Daniel of Jacksonville, Mr. William B. Henderson of Tampa and Mr. W. K. Hyer of Pensacola. They met in Tallahassee on March 11, and Mr. Henderson nominated Dr. Porter as State Health Officer and

Secretary of the Board. There was delay in learning his reaction since he was in New York City at the time. He accepted on March 14 and took the oath of office eight days later in Jacksonville.

Dr. Porter filled the position with interest and enthusiasm, but on Jan. 17, 1893 he wrote the Board he feared his health was not adequate to the demands "which the labor connected with the quarantine system of the State during the summer months in the future would impose upon him." He asked to be relieved of the duties; however, upon the "earnest and unanimous" request of the Board, he temporarily withdrew his resignation.

Near the end of the fourth term the duties began wearing more heavily upon his patience, causing considerable weariness. On Oct. 12, 1905, he wrote Mr. E. M. Hendry, president of the Board, he believed the office of health officer should be filled by a younger and more active man. "I think I have earned a release from the severe and exacting cares which necessarily are attached to the office of State Health Officer." Mr. Hendry credited resolutions from the Board and Boards of Trade and Chambers of Commerce of various cities with inducing Dr. Porter to modify his request and consent to remain "until the Board can with satisfaction to itself and the people of the State select and decide upon his successor." Governor Napoleon B. Broward described him as "great as the greatest of men in his line."

With this temporary arrangement, he continued working. A personal tragedy was almost overwhelming; he described the following year as one "having so much sadness and the bitterness of sorrow." Whatever the troubles and tragedies, they appeared to deepen his sense of responsibility, for during the next decade he made firm the foundation of public health in Florida.

The Board appointed him for another four year term on March 23, 1917, but he was not in sympathy with the administration that had assumed office the first of the year. On May 15 he submitted his resignation, writing to the Board that he believed he had fulfilled his obligations "entered into in an honest endeavor to promote the health interests of the state as well as to conserve the commercial life of Florida." Since the United States was at war, he continued: "I feel that I may now ask to be relieved, and permitted to return to the service from which I was automatically separated when I accepted, through a sense of duty, this position in 1889."[14]

Dr. Porter had served as State Health Officer for 28 years. His 70th birthday was October 21.

Late Years

Before the resignation became official, he requested reinstatement into the U. S. Army Medical Corps from an old friend, Dr. William C. Gorgas, Surgeon General. Impatient with delays and, to him, apparently little action from his letters and telegrams, he went to Washington, D. C., and, with the assistance of Dr. Gorgas, obtained a direct appointment from President Woodrow Wilson as lieutenant colonel. He was assigned to Fort Jackson, S. C., then transferred to Camp Johnston at Jacksonville where he served for the remainder of the war. He returned to his home in Key West in 1919 and over the following years served as city health officer, district health officer and president of the Chamber of Commerce without remuneration.

The probability that he soon would reach an age where active participation in civic affairs must cease caused Dr. Porter much concern and distress. A greater sadness came in February, 1922: the third child and youngest daughter, Roberta, died at age 48. As children, she and her sister, Mary Louise, and brothers, William Randolph and Joseph Yates, had filled the house, built in the early 1830's, with a particular gaity each time he returned home, laden with gifts indicating for them the beginning of an anticipated period of special merriment.

Appearances on the programs of the 52nd and 53rd Annual Meetings of the Florida Medical Association in May, 1925, and May, 1926, provided Dr. Porter the opportunity to record the highlights of a career that had spanned more than a half century. He apologized, to an audience that included few of his contemporaries, for the inability to recall events as accurately as he would have preferred but promised that another chapter would be forthcoming. Less than a year later, on March 16, 1927, he died in the room where he was born almost 80 years before.

"Dr. Porter desired to serve his fellow men to the last day of his existence, and no greater tribute can be paid to the memory of any man than to say: 'He lived to serve mankind.'"[15] "He was a pioneer in preventive medicine and his

merited achievements, rendering living conditions better in the state, are now history. As long as there is a Florida, his memory will be cherished."[16]

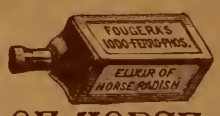
References

1. Files, Florida State Board of Health, Jacksonville.
2. Merritt, Webster: His Name Was Mudd, J. Fla. M.A. 38:724-727 (Apr.) 1952.
3. Files, Florida State Board of Health, Jacksonville.
4. Porter, J. Y.: Reply to Dr. C. J. Kenworthy's Paper, Proceedings of Annual Meeting, Florida Medical Association, 1888.
5. Ibid., p. 53.
6. Ibid., pp. 51-52.
7. Porter, J. Y.: Looking Backward Over Fifty Years of Health Work in Florida, Serial # 3, J. Fla. M.A. 12:71-74 (Aug.) 1925.
8. Merritt, Webster: A Century of Medicine, Gainesville, University of Florida Press, 1949, p. 159.
9. Hardy, Albert V., and Pynchon, May: Millstones and Milestones, Florida's Public Health From 1889, Jacksonville, Florida State Board of Health, Monograph Number 7, 1964, p. 8.
10. Porter, J. Y.: Looking Backward Over Fifty Years of Health Work in Florida, Serial # 3, J. Fla. M.A. 12:71-74 Sept.) 1925.
11. Proceedings, Florida Medical Association Annual Meeting, 1888.
12. Proceedings, Florida Medical Association Annual Meeting, 1887.
13. Proceedings, Florida Medical Association Annual Meeting, 1886.
14. Files, Florida State Board of Health, Jacksonville.
15. Warren, W. R.: Dr. Joseph Yates Porter, J. Fla. M. A. 13:271 (May) 1927.
16. Editorial: Joseph Yates Porter, J. Fla. M.A. 13:272 (May) 1927.

Dr. Sowder, P. O. Box 210, Jacksonville 32201.

1 BOT. $1.20—6 BOT. (in a box), $6.—1 QUART, $3.

FOUGERA'S



ELIXIR OF HORSE RADISH.

This Elixir, originated by E. FOUGERA, contains Iodine, Iron, Phosphorus, Sulphur and other active principles of anti-scrofulous and aromatic plants. Formula published*.

It acts as an alterant, diuretic, stimulant, emmenagogue and a powerful regenerator of the blood.

DOSE—For adults, a large tablespoonful at meal time; for children in proportion, adding some water. Pleasant to drink, possessing the virtues of FOUGERA'S COD LIVER OIL, prescribed for the same diseases, it is, when the Oil disagrees, advantageously substituted to it, or a dessert spoonful of Oil mixed with or followed immediately by the same quantity of Elixir may be taken while eating.

WHEN NOT EASILY PROCURED, ADDRESS PREPAID ORDERS TO

E. FOUGERA, Brooklyn, N.Y.

*See formula in Proceedings of Am. Pharm. Ass'n, 1867, page 153.

FOR SALE BY FIRST CLASS PHARMACISTS.

Reprinted from The New Orleans Medical and Surgical Journal, June 1887.

PAINLESS. RECTAL TREATMENT RELIABLE.

APHORISMS IN RECTAL DISEASES. 100 Pages, 22 illustrations. Diagnosis and all formulæ given. A book far in advance of anything heretofore issued on this specialty. Price, $2.00.



Terms very Reasonable. W. E. RYAN, M. D., FRENCH LICK SPRINGS, ORANGE COUNTY, IND.

Reprinted from The American Medical Digest, August 15, 1887.

History of Mental Health in Florida

Ann Spears Stover

Our sister States have gone forward in this work of humanity in a manner highly commendable to them and have provided for the care, maintenance and treatment of their lunatics and insane persons in a manner suited to their unfortunate condition, and that is worthy of emulation by us." This was Governor M. S. Perry speaking to the General Assembly of the State of Florida on November 22, 1858, 13 years after Florida had been granted statehood by the United States.

Governor Perry continued, "The General Assembly at its late session took a step in this direction, but I think stopped short of what might have been done, even then. An act approved December 27, 1856 provides that lunatics and insane persons shall, by order of a Judge of any of our Circuit Courts, be sent to and placed in Asylums of other States, and that the State of Florida shall pay for the maintenance of such as are destitute of pecuniary ability to maintain themselves; but this is not her only expense. She must also pay the cost of transportation to and from such Asylums." Further on in his message to the General Assembly, Governor Perry comments that "by an act approved January 8, 1853, directed that William Crawford, then a prisoner in a common jail in Hernando County, but who had been adjudged a lunatic by the Circuit Court of that County, be removed from said jail and placed in an Asylum of some neighboring State."

In 1862, the Governor took money from the contingency fund to pay back bills for patients that Florida had sent to asylums outside the state's boundaries. The Florida Comptroller, in his 1872 report to the General Assembly, comments on the fact that Florida had agreements with Georgia and South Carolina to pay, semi-annually in advance, $250 per person per annum, plus the cost of necessary clothing. Following payment from the contingency fund of some of the back bills owed by the state for the care of their "lunatic and insane" the Comptroller wrote to the Governor as follows: "Your Excellency not only relieved me of an embarrassing duty of asking these institutions to wait for another appropriation when they had already been put off in the same manner from year to year, for portions of the sum due them, but you have saved the State from a most disgraceful act of inhumanity, that of placing her indigent lunatic children in the asylums of other States and leaving them to be supported at the expense of those states, or sent back and turned at large to perish for want of attention or prey upon her other citizens."

One can assume that in Florida as a territory and after becoming a state, the mentally retarded and the mentally ill, without distinction as to which health problem they suffered, were, as in other states, driven from towns, beaten, put in the stocks, made fun of by other citizens and were fortunate to find sufficient garbage from homes and stores to keep themselves alive. Only in the cases of families whose wealth was sufficient to provide a separate building with bars on the window and a locked and barred door, or an attic,

Mrs. Stover is the wife of an FMA member, Richard F. Stover, M.D., in private practice in Miami.

most often unventilated, did this situation not apply. Irons and chains were used in other states and one must assume, this being the method of treatment in other states, that it was also true in Florida. All of these actions on the part of citizens were inhumane but the mysticism and the differences noted in the "lunatic and insane" made a problem with which, in ignorance, they were unable to cope in any other way.

By 1873, it was realized that something had to be done to provide for the care and treatment of the "lunatic and insane" within the boundaries of the state. Georgia and South Carolina were refusing to longer take citizens of Florida, their asylums not being large enough to accommodate the needs of their own state, and Florida being constantly behind in paying its honest debt for the care of Floridians. Augmenting the facilities of these other states, some of the "lunatic and insane" had been taken care of by private citizens within the state who were paid for this service. At Florida's very beginning, the problem had been in the realm of authority of the county, later in the duo-authority of the county and the state and then of the state.

On January 21, 1874, the Florida Senate requested that the Congress transfer the barracks at St. Augustine to Florida for a "Lunatic Asylum." The United States, however, did not see fit to transfer these buildings and land to the state for that purpose. Then began discussion about placing the lunatic asylum in an unused building in the state prison quadrangle located at Chattahoochee. The United States Government had ceded 10,278 acres of land including Fort Jackson to the state, this land being used for the state prison.

According to Comptroller C. Drew's report in 1876, there were 45 state-supported insane, eight outside the state at a cost of $3,200 per year and the rest cared for by private citizens within the state who were paid to care for them.

Florida was practically forced into taking action to provide a facility within the state's boundaries. The proceedings of the 1874 General Assembly contain the report of Comptroller C. A. Cowgill which in part says, "The debt due the Lunatic Asylums of other States for the treatment and care of our Insane, amounting on the first of January, 1878 (note the typographical error in the date) to $12,387.29, has been paid and also their charges for the past year." Finally, on March 2, 1877, an act was passed appropriating $3,000 for "the repair, alteration and construction of buildings" and for the indigent insane of the state; and $700 for the transfer of lunatics then in other states to the Florida asylum. The transfer of patients was made in June 1877. State Medicine began in Florida at the site of the state prison in Chattahoochee.

In "A Century of Medicine in Jacksonville and Duval County," Webster Merritt, M.D. writes about the beginning of the present Duval County Medical Center: "Early in the seventies the following buildings were constructed, a wooden building which served as a hospital ward and a brick building was used as an asylum, a small 'double-roomed' building called the dead and wash house and several small one story buildings, including a kitchen and chicken house. This was, after addition of another building in 1877, known as the Duval County Hospital and Asylum, sometimes referred to as the 'County Poor House.' "

In Doctor Merritt's book one finds the account of a local Jacksonville newspaper reporting on the early Duval County Medical Center: "On approaching by the Oakland Road, past the graveyard, the old building which formerly and still fullfills the condition of an asylum, comes in sight first.

"Around these county buildings, a suitable fence is now being put up, which keeps out the hogs and restrains the inmates from taking extended walks. The Asylum has had a cheap verandah put up on the south side . . . and has been clapboarded . . to keep out the rain. Inside it is divided into four ordinarily sized rooms . . . the two larger of which are the male and female wards . . . the other two rooms the Superintendent's and a general storeroom. All of these rooms are kept in as cleanly a condition as possible."

On the subject of food, the newspaper reports, "The bill of fare for those in the hospital is, of course, better than for the Asylum inmates."

Several investigations and studies of the hospital at Chattahoochee, which remained the only facility provided by the state until after World War II, have been made from time to time. To give an indication of the condition prior to World War I, the report of the Legislative Committee to Investigate the Hospital of 1905 has been selected. The written record of what was done, and how, is in greater depth in this particular investigation than in the others recorded. At this time, Napo-

LIST OF LUNATICS *who have been or now are supported or assisted by the State of Florida in accordance with the provisions of Chapter* 792, *Laws of Florida.*

NAMES.	COUNTY OF WHICH A RESIDENT.	WHEN DECLARED A LUNATIC.	BY WHAT AUTHORITY.	WHERE PLACED.	WHEN.	REMARKS.
1 -Margaret A B Harvey	Jackson			Ga Lunatic Asylum	July 11, 1846	Supported by State from July 10, 1865.
2 William Crawford	Hernando	Jan'y 8, 1853	Act of Legislature	So Ca Lunatic Asy.	March 24, 1853	Discharged cured March 16, 1864.
3 -Isaac King	Leon	Jan'y 17, 1857	Judge J W Baker	do do	Jan'y 26, 1857	Died June 4, 1857.
4—John Williams	Leon	Jan'y 17, 1857	do	do do	Jan'y 26, 1857	Died July 16, 1861.
5—Caroline Bell	Leon	April 27, 1857	do	do do	May 19, 1857	Discharged cured Oct 14, 1857.
6—Joseph Phelps	Santa Rosa			Ga Lunatic Asylum	Jan'y 22, 1858	Died June 22, 1864.
7—Robert C Gray	Gadsden			do do	Dec 28, 1858	Died Oct 14, 1861.
8—J R Hendry	Gadsden			do do	Nov 2, 1859	Died Sept 15, 1862.
9—Julia A Sanders	Leon			do do	July 10, 1860	Died Oct 8, 1863.
10—Jefferson Eubanks	Gadsden			do do	July 10, 1860	Died May 27, 1865.
11—Sealy Scoggins	Liberty			do do	Sept 1, 1860	Died July 20, 1862.
12—Theresa Colson				So Ca Lunatic Asy.	May 26, 1861	Died May 6, 1864.
13—Henry Cook	Jackson			Ga Lunatic Asylum	April 24, 1862	
14—Susan Kelly	Madison	Dec. 10, 1862	Legislature	With friends		Father paid $10 a month.
15—Eliz. Caulfield	Marion	Dec. 4, 1862	Judge B A Putnam	So Ca Lunatic Asy.	Jan'y 24, 1863	Died August 10, 1872.
16—Willfred Horton	Jefferson			Ga Lunatic Asylum	July 12, 1863	Died Act 26, 1868.
17--Charles W West	Leon			do do	July 12, 1863	Deserted May 14, 1868.
18—Mrs. Smith†	Taylor	Nov. 27, 1863	Legislature	With friends		Brother paid $10 a month.
19—J M Grambling	Leon			Ga Lunatic Asylum	April 10, 1864	
20—Laban Carraway	Jackson			do do	May 17, 1864	
21—Eliz. Olson	Leon			do do	April 2, 1866	
22—Mary S Leak*	Franklin	Nov., 1867	Judge A H Bush			
23—Sarah E Lanier*	Franklin	Nov., 1867	do			
24—Neil Horton	Escambia	Oct. 29, 1868	Judge H G Plantz	Mt Hope Lun Asy near Baltimore	March 2, 1869	
25—Annie G Church				So Ca Lunatic Asy.	Jan'y 23, 1869	Discharged Jan'y 26, 1871.
26—Eliz. Triest	Gadsden	Dec. 19, 1869	Judge P W White	With friends		$25 a month paid to Amos Rouse.
27—Lavinia M McLeod	Taylor	Jan'y 3, 1870	Judge T T Long	do		$150 a year paid to J H Wentworth.
28—Chapman Hogan	Madison	July 1, 1871	Judge Wm Bryson	So Ca Lunatic Asy.	July 18, 1871	
29—Benjamin Chaires, Jr.	Leon	Dec. 18, 1871	Judge P W White	do do	July 18, 1871	Died April 6, 1873.
30—Julia A Thomas	Jefferson	Jan'y 14, 1873	do	With friends		$35 a month to T G Letchworth.
31—Margaret Singleton	Gadsden	March 1, 1873	do	do		$45 a month paid to Davidson & Love.
32—Mary Smith†	Taylor	April 28, 1873	Judge Wm Bryson	do		$8 a month paid to J H Wentworth.
33--James T Curry	Columbia	Aug. 25, 1873	do	do		$10 a month paid to Mrs. Curry.

*These two persons were ordered to the Georgia Lunatic Asylum but were not received, and were cared for by John B. Matthias, and on Nov. 1868, Judge Plantz ordered that Mr. Matthias should receive $416. for care and clothing for Mary S. Leak for 416 days, and $222.75 for care and clothing for Sarah E. Lanier for 214 days. †Mrs. Smith mentioned as No. 18 is the same Mary Smith mentioned as No. 32.

Portion of Comptroller's Report for 1873-1874

Diagnosis Showing the Total Number Afflicted with Each Disease Mentioned, During the Seven Years Ending December 31st, 1900. Admissions, 1894 to 1900, Inclusive.

Physician's Diagnosis.	*No.*
Mania, Acute	467
Mania, Chronic	62
Mania, Recurrent	91
Monomania	67
Melancholia	179
Dementia	100
Epileptic Mania	47
Epilepsy, Simple	77
General Paresis	19
General Paralysis	2
Idiocy	40
Moral Insanity	51
Not Insane	13
Total	1,216

Excerpt from 1901 Superintendent's Report

leon Bonaparte Broward was Governor, Hon. Albert W. Gilchrist was Speaker of the House of Representatives and the Hon. Park M. Trammell was President of the Senate.

The charge to the committee was to "visit, inspect, investigate and report its findings of the condition, needs and affairs of the Hospital for the Insane of the State."

The committee made its report prior to the end of the session: "The Committee feels justified in saying that many evils and irregularities that have existed in and about the institution, its management and influences could have been corrected if the necessary watchful supervision had been exercised." This was criticism of the State Board of Institutions (the Cabinet) which was the supervising body. A long reply was made by the State Board of Institutions reminding the legislators that in 1903 many laws requested by them to improve the Hospital for the Insane of the State had not been passed by the 1903 legislature.

In reporting on the facility, the committee said, "The Committee represents to you that Ward No. 1 is in an extremely unsanitary condition, that it is cruel and inhuman to compel even human beings totally oblivious of their surroundings to live and stay in it. Ward No. 2 is over Ward No. 1 and needs thorough repair, especially the floor, which is worn and open, the filth of this ward runs through the floor and drops in Ward No. 1. Ward No. 3 also needs repairing; and your committee would urge that in rebuilding the interior of these wards due consideration be given to ventilation and circulation. Your committee would further represent to you that one of two things must be done at once; Either take out of the institution 150 to 200 persons that do not belong in an indigent hospital for the insane or construct another ward sufficiently large to accommodate 150 to 200 people. Such building will cost about $20,000.00. Your Committee would suggest that the interior, if constructed, be as nearly fire proof as can be made by using as little wood as possible."

One of the buildings mentioned in this report as unfit for human habitation was still in use until the middle part of the 1950's. We must assume two things about the 150 or 200 people mentioned—either they were not indigent, or they were mentally retarded rather than ill. At the present time there is still an accumulation of mentally retarded in the hospital at Chattahoochee; some 1,000 of them were domiciled at Chattahoochee in 1966. There is mention of the mentally retarded being in the hospital throughout investigations, surveys, studies and reports, although special facilities for the mentally retarded were opened in Gainesville in 1915.

A new superintendent had come to Chattahoochee, Captain B. F. Whitner. Most of the questions and answers posed by the investigating committee of the 1905 legislature were concerning past evils and practices and did not apply to Captain Whitner, whose tenure had been very short prior to the investigation. One question posed to him and its answer are of interest, "What experience have you had in the care and management of the insane, or persons affected with disturbed minds?" His reply was, "I have had no experience only since I have been here."

Charles A. Grambling, who was employed at the hospital from October 1, 1901 to June 16, 1904 as a bookkeeper, testified in part as follows:

Q. "Were the patients ever forced to work?"

A. "I remember one instance when a man was forced to work. A white man from Levy County, named Ben Morris; they were going to pull fodder, and he did not want to go. The attendant instructed two men to bring him, and they took

him by the feet and dragged him until he promised to go. Sam Cobb, one of the teamsters, refused to work one day and the attendant lifted him up by the neck two or three times."

Q. "Are they required to work here?"

A. "They are required to do work that no human person should do. They frequently pull wagons loaded with supplies from the station. They are hitched up to plows like mules and plow . . . The dynamo for the electric plant was hauled by patients from the station."

Q. "Are there no mules to do this sort of work?"

A. "There were 11 mules and four horses at the time the people were hauling the things."

D. W. C. Yarborough, who was employed at the hospital, testified:

Q. "Can you account for the increased death rate?"

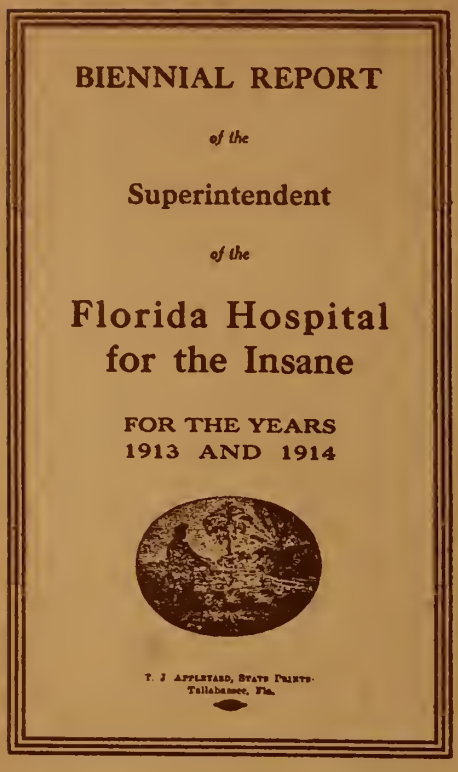
A. "The increased death rate in 1904 was due, as far as I can judge, to the peculiar condition that seemed to prevail during the last 12 months. I think about six counties that were represented here, the patients were not able to stand the trip and died within 24 hours after coming here and one died on the way here. As well as I can judge the death rate during the last year was 40 per cent patients that had been in the institution less than three months. The increased death rate was on account of local conditions. Another reason is the drinking water. While I am not a physician, under the prevailing conditions here, I am convinced that one source of the condition here is from the drinking water." A physician questioned later bore out this testimony and said that the water was not sanitary nor healthful.

Dr. R. F. Goddard was employed as a physician and surgeon at the hospital, was appointed by the State Board of Institutions, and remained there from January 14, 1902 until July 1, 1903. His testimony revealed that when he took charge there was only "one girl in the institution that knew even so much about nursing as to count the pulse or register the temperature." There was not even a surgical operating table at the hospital and the only equipment by way of surgical apparatus was one small case of operating instruments. Asked what the sanitary condition of the institution was, he answered: "When I took charge there, I did not see how it was possible for a human being to exist in some of the wards."

Further questioning disclosed that there was no pharmacist and that Dr. Goddard had "to do my own compounding." When asked if the employees "gave you to understand that your authority was not to be regarded," he answered "Yes, sir." It afterwards developed that Dr. Gwynn (the superintendent) called a meeting of the employees of the institution at 8:00 p.m. on February 4, 1903 in the amusement hall and among other things stated that he was the head of the institution and was managing it, and that no employee would be held responsible for the execution of orders issued by anyone except himself, or by his supervisors for the female and male departments, and during his absence, his wife would act in his capacity, or the bookkeeper, or such a one as he might appoint. He stated that the physician *might* give medicine in case of sickness. Dr. Goddard when asked if he was sure he (the superintendent) used the word might answered, "He emphasized the word might."

Further, Dr. Goddard testified: "I was unable to do the work I could have done under a different administration. . . . The employees of the institution were not as efficient as could have been with the same expense. This of course, would reflect on the employment of too ignorant a set of employees or selecting the employees from too ignorant sets of people." Asked if he had observed evidence of cruelty or unnecessary treatment of the patients by attendants, he answered "Yes, sir." The committee further asked, "Did you receive instruction to treat those suffering with mind troubles?" His answer was, "That was the presumption." Then he was asked, "Was there any special effort made to produce sanity?" He answered, "No, sir."

Dr. L. D. Christie had been at the hospital about 11 months, from July 1904 until about one month before testifying. This testimony as to the method made for treatment of the diseases of the mind in regard to a cure was that "The general practice would be to build up the system and treat the mind as much as possible." When asked what facilities he had for treating diseases of the mind, he answered, "Not the best in the world." He further told that there was hardly any "apparatus." He said there were no x-ray, electric batteries and so forth. "We had some surgical instruments." When he was asked for a description of a physician at the hospital, he replied, in part,


BIENNIAL REPORT

of the

Superintendent

of the

Florida Hospital for the Insane

FOR THE YEARS 1913 AND 1914

T. J. APPLEYARD, STATE PRINTER
Tallahassee, Fla.

that "a physician there was something like a bump on a log about fixing the prescriptions and sending them to the hospital."

Dr. Christie was questioned about the treatment of the patients at the hospital by attendants and others.

Q. "Was there any special incident where the patient came under your attention for treatment on account of cruel treatment?"

A. "Yes, sir, Eugene Davis, from Live Oak, was severely whipped and for four or five days was in a very bad shape, and was put in the hospital and he remained there until he died."

He did say that he could not testify that the beating was what caused Eugene Davis to die about one month later. Dr. Christie testified to further cruelties: "whippings, kickings, chokings and stampings."

The committee report was accepted by the legislature with one dissenting vote by a representative who felt that the committee had overstepped the bounds of its charge.

A search of the Florida archives did not reveal any fuller nor more extensive report than the one used here. With small exception in appropriation for repair to buildings, the matter was dropped and forgotten. This seems to have been the fate of practically every investigation and/or study that was made. There seemed to be four prevailing reasons for this: the lack of real supervision by the State Board of Institutions (the Cabinet), the more pressing needs for tax money in the state felt by the legislatures, the overglowing reports of the superintendents and the desire of the population to isolate this problem in an area far from where any of them lived and, because it had an unknown quantity and was unpleasant to face, to continue to forget these patients.

A little more money was asked for the hospital by the State Board of Institutions in 1903. They believed that 32 cents per day was not quite enough. The legislature apparently was of the opinion that this was more than ample even though 32 cents per capita was below the national average.

Dr. Louis DeM. Blocker, who in 1890 held the position of "Physician" at the hospital, recognized the need for early treatment. He considered mental illness to be a disease of the brain just as one had diseases of the body. In 1899, however, in the report of the superintendent of the Florida State Hospital, listed as causes of insanity are "cigarettes, exposure, poverty, love and faith cure." Until the increase in the size of the staff and recognition by the staff of more modern methods of treatment in 1931, the care of the patients was for the most part custodial and physical and practically no attention was paid to the curing of the mind. Superintendents' reports throughout the years indicate the emphasis that was placed on the low number of escapes, the physical ailments of the patients, the low amount of money spent by them for patients' care and on other things which, in reality, had nothing to do with the real reason the patient was in the hospital, mental illness. Pride is shown in these reports in the beautiful grounds, the buildings, the small per capita cost of care and the fact that the staff managed though it was never as large as requested from the legislature.

Doctors employed at the hospital were burdened with treatment of the employees for physical ailments in addition to the care they had to give to the inmates. A visiting staff of physicians and surgeons for the physical welfare of the patients and employees was in use from the early 1900's. These included a dentist.

Superintendents have been both lay and professional people. The treatment of the patients does not seem to have been any better or any worse under one than under the other. Trained psychiatrists at Florida state hospitals were nonexistent until recent years.

B. F. Whitner was still superintendent of the Florida State Hospital for the Insane in 1909. By this date the average patient census had grown to 852.5 and by 1910 was 911.8.

On October 1, 1919, with H. Mason Smith, M.D., as superintendent, a School for Nurses was established under the supervision of Miss Pearl Summerford, R.N. Arrangements were made for a reciprocal program with other hospitals. The students were taught general nursing. They did not receive any special training for psychiatric cases. This has held true in latter years. No special training has been forthcoming in psychiatric nursing.

By June 1929 the patient census had risen to 3,296 and by the same month in 1930 it had risen to 3,407. The large influx of people who came to the state during the Florida "boom" had taken



Receiving Hospital, Florida Hospital for Insane, 1913-1914.

place and the hospital had grown accordingly.

The law continued to take precedence over mental illness and treatment of the patient. Until after World War II, with only one hospital in the state, known in the latter years of this stage as the Florida State Mental Hospital, those adjudicated mentally incompetent were, by law, remanded to the sheriff. The time between such adjudication and time when patients were picked up by someone from the hospital to be taken to Chattahoochee was, except in small instance, spent in jail without medication or treatment. It was more common than not to have patients in the county



Negro Male Building, Florida Hospital for the Insane, 1913-1914.

jails for as long as six months, and sometimes longer.

With some increase in the size of the professional staff, and with a recognition on its part of more modern methods of treatment, a beginning was made in 1931 to pay more attention to the major reason for the patient being at the state mental hospital. The only research found in the records to have been done at the state hospital, until recently, was reported in 1932. Under the sponsorship of the health division of the Rockefeller Foundation, research was done on giving naturally induced malaria to cerebrospinal syphilitics and parotics. The research was done by Dr. Mark P. Boyd and Dr. Warren K. Stratman-Thomas. Of the 57 cases which could be "fully considered" when the report was made in 1932, 12.2% had improved sufficiently to be paroled from the institution and 40.1% showed varying degrees of mental improvement. The report noted that where no evidence of mental improvement was apparent, there was an apparent improvement in the physical condition of the patient. Insulin and Metrazol shock therapy were used at the hospital starting in 1939. A neurosurgeon from Jacksonville made periodic visits to the hospital in Chattahoochee and neurosurgery was used from 1937. Mechanical restraints and barred windows were still in use in the 1940's.

At the 1947 Conference of Social Welfare held in the Bayfront Auditorium in Miami, Dr. Herman Selinsky, who at his own expense and time had visited the Florida State Hospital at Chattahoochee, gave an indignant report on his findings and also on the lack of facilities and services throughout Florida. Concern was shown by those attending but they believed at that time they did not have the staff or finances to do anything about it. A group of Dade County citizens, however, having heard this program, met and formed the first citizen's group for the mentally ill, a

voluntary health agency called the Southeast Florida Mental Health Society. In the spring of 1949, Mr. Steve Trumbull of the Miami Herald wrote, with vivid photographic documentation, an exposé of the conditions at the hospital and this newspaper, with editions throughout the state, aroused the interest of Florida citizens. In 1950 the Florida Association for Mental Health was organized by interested professionals and citizens from the larger urban sections of the state.

Following World War II in 1947 land and the buildings from Dorr and Carlstrom Air Fields near Arcadia in DeSoto County were obtained by agreement between Florida and the United States government and an "annex" to the Florida State Mental Hospital was opened there.

In his campaign to be Governor of Florida in 1952, Dan McCarty talked about the need for new facilities for the mentally ill and in February 1953 he appointed a group of citizens and professional personnel which became the first Governor's Advisory Committee on Mental Health. In his address to the legislature in the first part of April 1953, he asked for $10 million to establish a state hospital in the Southeastern region of the state. Patients from this area had to travel part way to Chattahoochee one day, spend the night in a jail and finish their trip the next day. Although the legislature cut the appropriation to $5 million, nevertheless plans and work were begun and in 1957 the doors of the South Florida State Hospital were opened. Uniquely, after 112 years of statehood, this was the first planned mental hospital that the state had ever built.

At the present time, including a hospital built a few years later at Macclenny, there are four state mental hospitals: Florida State Hospital at Chattahoochee, Northeast Florida State Hospital, South Florida State Hospital and the G. Pierce Wood Memorial Hospital. Under a law passed in 1965, each hospital now operates separately rather than as an "annex" or part of the hospital at Chattahoochee.

In 1950 there were less than 50 beds available in general hospitals throughout the state for care and treatment of the mentally ill. Private sanitaria were and have continued to be few. After the establishment of many county mental health associations throughout the state, citizens began to realize the lack of community facilities, and to



Superintendent's residence (left) and Tower Building (right), Florida Hospital for the Insane, 1913-1914.

work toward having at least a minimum. This goal has not been accomplished yet in all Florida counties, but progress has been made. There are, for example, at present more than 1,000 beds in general hospitals for the care and treatment of the mentally ill. Following the passage of laws in the Congress appropriating money to be matched by the state and counties for clinics, Florida began to establish child guidance clinics, which now number more than 25. These facilities have preceded and have brought about a realization on the part of the public that more complete community facilities should be available, and that all those possible should be cared for and treated in their community rather than sent to a state hospital. Thus, at the present time, in various stages of building and planning, eight community mental health centers are approved in the state.

Only a few years back, there were few psychiatrists in Florida and no provision was made for the training of psychiatrists and members of ancillary professions in the state until the 1950's. Florida State University had a School of Social Work and the universities throughout the state had departments of psychology but few physicians in the discipline of psychiatry practiced within the boundaries of Florida. The first Florida medical school was not established until the 1950's, and until the building of the institute at Jackson Memorial Hospital, no training for psychiatrists was available within the state.

It is a paradox that often the legislature has appropriated money requested by state mental institutions to provide for sufficient, or at least additional, staff positions only to have that money return to the General Fund of the state when these positions could not be filled, rather than remain with the institutions to be used for other needs such as better food, housing or rehabilitation, because the present law, unchanged since Florida's beginning, states that appropriated money must be used only during the time for which it was appropriated and only for that purpose for which it was budgeted.

On January 1, 1885, State Comptroller William R. Barnes in his report to the legislature said, "It will be seen that the number of these unfortunates to be cared for by the State is increasing rapidly . . . These extraordinary expenditures, exceeding the appropriation by $10,000, were necessary to the comfort and safe-keeping of the patients, and the deficiency asked for, for the purpose of meeting them, will doubtless be cheerfully supplied by the representatives of the people." These "extraordinary expenditures" as far as could be ascertained, were for repairs to delapidated buildings so that patients would not be harmed. A review of the facts would not indicate that any sum of money was "cheerfully supplied." The requests to the legislature for the most part were for more and more building and the absolute minimum for food, clothing, housing and so forth. A review of some of the expenditures in the superintendent's reports is a guide to this. In 1938-39, for the expenditures at the Florida State Mental Hospital at Chattahoochee, the superintendent lists 34.5% for food, 21% for capital expenditures, 17.9% for housing expense and 11.6% for medical expense. This 11.6% we must assume was for physical and mental treatment of the patients and for physical treatment of the staff. The 1939-40 report shows 40.2% for food, 23.3% for housing and 14.3% for medical expense. For the most part, a search of the superintendent's reports will show that a small percentage of funds was spent to help the patient be cured of his mental disease. This leads one to wonder if the underlying reason for a state mental hospital, until recent years at least, has been that of an isolated place to put people with mental illness where society does not have to worry about them, rather than being, in any real sense, a hospital for the care and treatment of the mentally ill.

My thanks go to Miss Lewella Ashburn Jones; the staff in the office of the Secretary of State, Tom Adams; the superintendents of the hospitals; Dr. W. D. Rogers, Director, Division of Mental Health, State of Florida; Mr. John Redstrom, Public Relations Director, Florida Association for Mental Health, and all others who gave of their time and knowledge in helping in the research for the writing of this history.

Mrs. Stover, 6145 S.W. 92nd Street, Miami 33156.

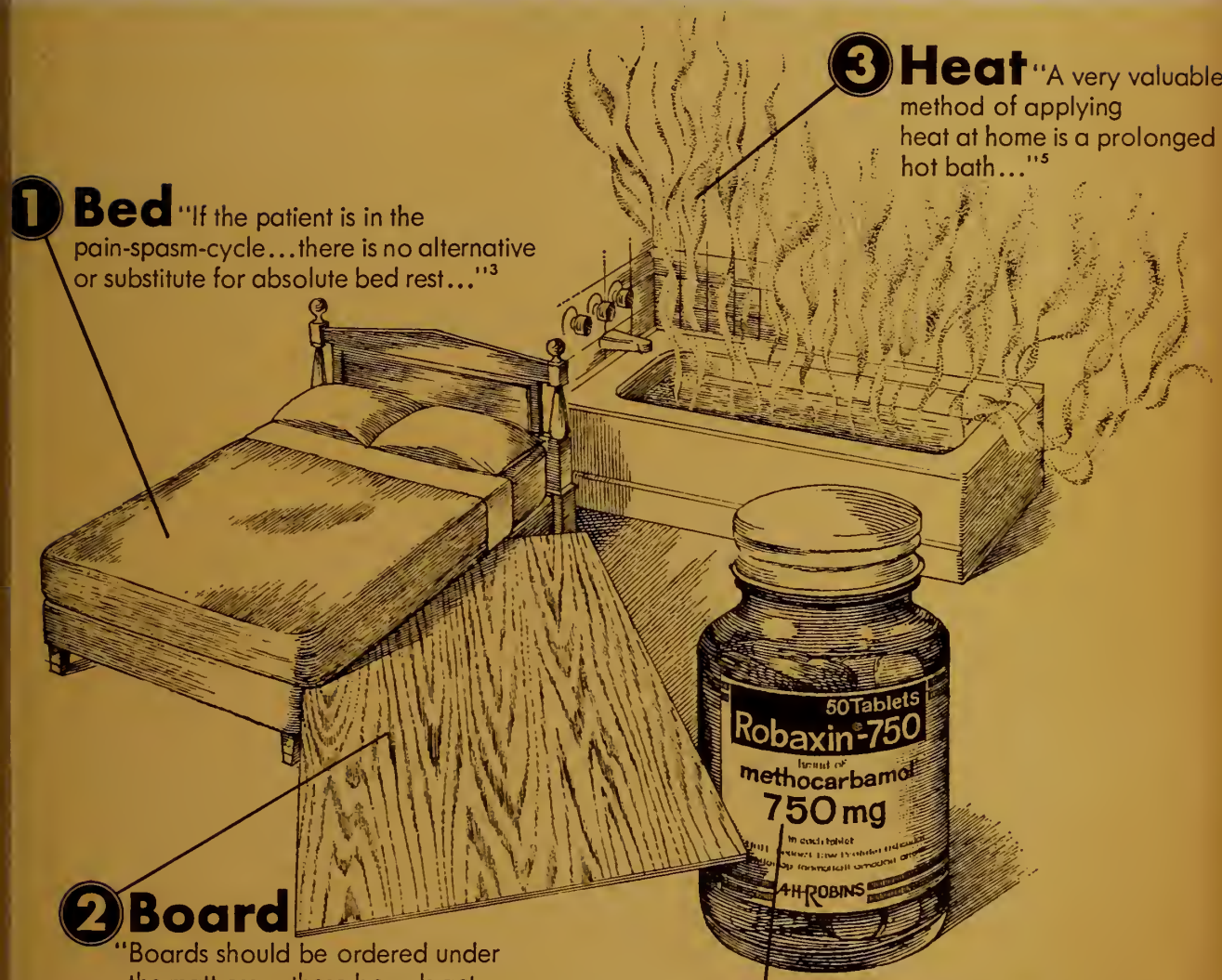
Fee Bill of 1792
Medical Society of South Carolina

	£	sh.	d.
For a vomit or a purge, each	0	1	6
For mixtures, decoctions or infusions in phials, each	0	5	0
For powders according to their number and qualities each, from 1 to	0	1	6
For pills by the dose	0	1	0
For boluses, draughts, and other active medicines taken at once, each	0	3	0
For Blistering plasters according to size, each from 2 4 to	0	4	8
For electuaries by the gallipot	0	7	6
For a visit in the city in the day	0	5	0
For a requested visit after it is dark	0	10	0
For rising out of bed and visiting according to the weather and other circumstances, from 1. to	2	0	0
For medical advice or opinions given by letter or otherwise, according to the difficulty of the case, from one guinea to three guineas			
For consultations	3	5	3
For dressing sores according to circumstances, from 1. to	0	3	6
For extracting a tooth from a white person	0	9	4
For extracting a tooth from a slave	0	4	8
For bleeding a white person	0	9	4
For bleeding a slave	0	4	8
For cutting an issue, inserting a seton, or opening an abscess, each	0	15	0
For reducing dislocation of the small joints, from 10 to	1	0	0
For reducing dislocations of the large joints, from 40 to	5	0	0
For setting fractur'd bones, from 20. to	5	0	0
For cutting for the fistula in ano	5	0	0
For amputating a finger or toe	1	0	0
For amputating the large limbs, from 5 £ to	7	0	0
For the operation of the trepan	10	0	0
For all other operations in surgery, in a relative proportion to the preceding.			

LOW-BACK PAIN

A CONSERVATIVE, FOUR-POINT PROGRAM

The low back pain that is most frequently seen in general practice is mechanical in nature, i.e., postural back pain, joint dysfunction and acute back strain.[1,2] For this type of discomfort, a conservative regimen is usually sufficient to relieve aches and pains, and to help keep the patient functioning. Components of this basic program include:



1 Bed "If the patient is in the pain-spasm-cycle...there is no alternative or substitute for absolute bed rest..."[3]

2 Board "Boards should be ordered under the mattress...these boards act by immobilizing the spine..."[4]

3 Heat "A very valuable method of applying heat at home is a prolonged hot bath..."[5]

4 Robaxin®-750 (methocarbamol, 750 mg. capsule-shaped tablets) A well-tolerated[6] skeletal muscle relaxant, methocarbamol helps relieve spasm "...without interfering with normal tone and movement."[7] And there is little likelihood of sedation.[6]

dicated for relief of skeletal muscle spasm. **Contraindicated in** ypersensitive patients. **Side Effects** (lightheadedness, dizziness, rowsiness, nausea) may occur rarely, but usually disappear on reduced osage. Hypersensitivity reactions develop infrequently. See product erature for further details. **Also available:** Robaxin® Tablets ethocarbamol, 500 mg.) Robaxin Injectable (methocarbamol, 1 Gm./10 cc.)

eferences: (1). Godfrey, C.M.: Applied Therap. 8:950, 1966. (2). Gottschalk, A.: GP 33:91, 1966. (3). Rawe, M.L.: J. Occup. Med. 2:219, 1960. 1). Cozen, L.: South Dakota J. Med. 18:26, 1965. (5). Soto-Hall, R.: ed. Sc. 14:23, 1963. (6). Weiss, M. and Weiss, S.: J. Am. Osteopath. A. :142, 1962. (7). Feuer, S.G., et al.: New York J. Med. 62:1985, 1962.

A·H·ROBINS A. H. ROBINS COMPANY RICHMOND, VIRGINIA 23220



NEW EVIDENCE:

Pro-Banthīne® (propantheline bromide) **gives positive, selective benefits in gastrointestinal disorders.**



Intragastric photograph of pyloric region showing complete relaxation of pyloric sphincter with 6 mg. of Pro-Banthine intravenously.

AN IMPORTANT PROBLEM in managing gastrointestinal disorders has been the choice of an anticholinergic agent which will act positively and selectively on the gastrointestinal tract without extensive secondary effects.

Recent direct observations with the cinefibergastroscope and intragastric photography[1] visually confirm previous evidence that Pro-Banthine does, indeed, possess such selective activity.

Barowsky and his associates demonstrated that a minimal dose of 6 to 8 mg. of Pro-Banthine intravenously produced complete relaxation of gastric activity. Secondary effects were not significant.

By contrast, it required 0.8 mg. or double the usual dose of atropine intravenously to achieve similar gastric relaxation. Side effects of this dosage of the belladonna alkaloid were pronounced. Ventricular rates were as high as 150 per minute.

For positive, selective anticholinergic benefits Pro-Banthine is indicated in patients with peptic ulcer, gastritis, irritable colon and other forms of gastrointestinal hypermotility.

Dosage: The maximal tolerated dosage is usually the most effective. For most *adult* patients this will be four to six 15-mg. tablets daily in divided doses. In severe conditions as many as two tablets four to six times daily may be required. Pro-Banthine (brand of propantheline bromide) is supplied as tablets of 15 mg., as prolonged-acting tablets of 30 mg. and, for parenteral use, as serum-type ampuls of 30 mg. The parenteral dose should be adjusted to the patient's requirement and may be up to 30 mg. or more every six hours, intramuscularly or intravenously.

Contraindications: In glaucoma or severe cardiac disease.

Precautions: Since varying degrees of urinary hesitancy may occur in the elderly male with prostatic hypertrophy, this should be watched for in such patients until they have gained some experience with the drug.

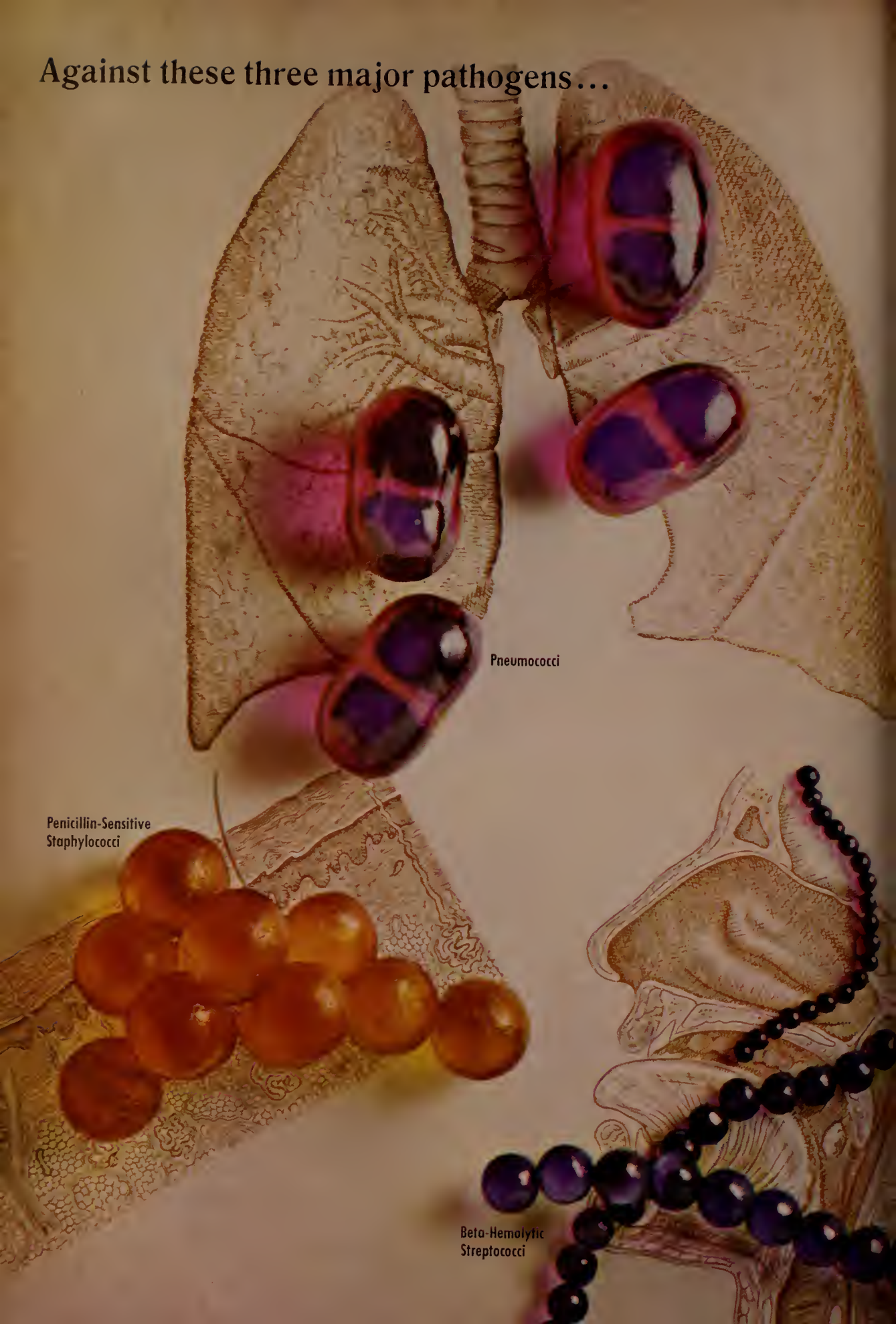
Although never reported, theoretically a curare-like action may occur with possible loss of voluntary muscle control. Such patients should receive prompt and continuing artificial respiration until the drug effect has been exhausted.

Side Effects The more common side effects, in order of incidence, are xerostomia, mydriasis, hesitancy of urination and gastric fullness.

1. Barowsky, H.; Greene, L.; Bennett, R., and Buganza, G.: The Effect of Anticholinergic Drugs on Gastric Motility and Pyloric Function, Scientific Exhibit, Annual Convention of the American Medical Association, Chicago, Illinois, June 26-30, 1966.

SEARLE *Research in the Service of Medicine*

Against these three major pathogens...



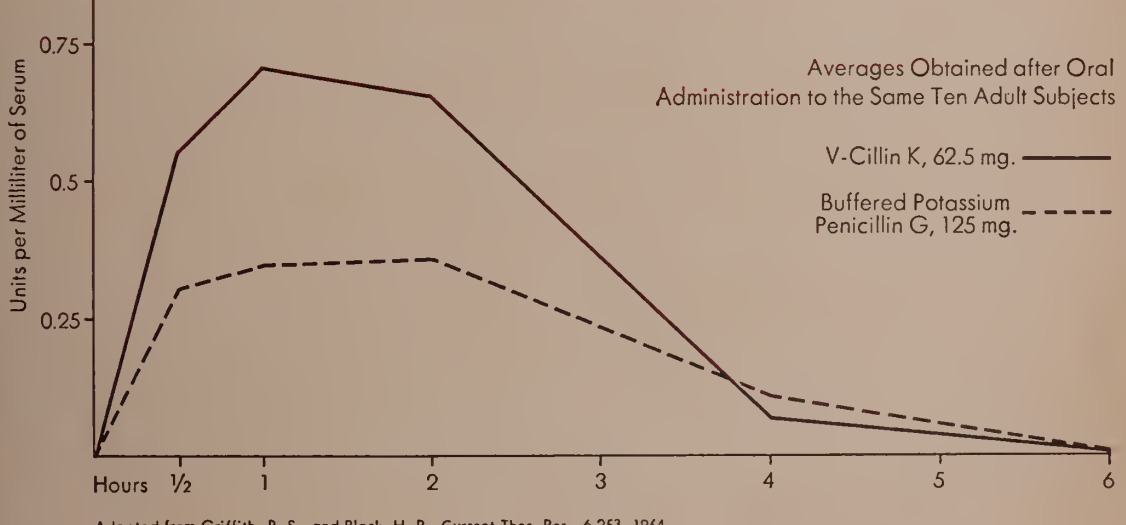
V-Cillin K® provides dependable oral antibacterial activity

because it combines a high degree of in-vitro activity...

Antibiotic	Stoph. Aureus (Penicillin-Sensitive) MIC (mcg./ml.) Median	Range	Streptococcus, Group A MIC (mcg./ml.) Median	Range	Diplococcus Pneumoniae MIC (mcg./ml.) Median	Range
Penicillin V	0.02	0.02-0.04	0.02	0.003-0.4	0.01	0.005-0.2
Penicillin G	0.02	0.005-1.6	0.005	0.002-0.2	0.02	0.01-0.1
Methicillin	1.6	0.4-6.3	0.2	0.1-0.4	0.2	0.1-1.6
Oxacillin	0.4	0.1-3.1	0.04	0.02-0.4	0.1	0.04-0.8
Cloxacillin	0.2	0.2-0.8	0.1	0.1-0.8	—	—
Nafcillin	0.4	0.2-0.8	0.04	0.02-0.1	0.02	0.02-0.2
Ampicillin	0.2	0.1-0.8	0.02	0.01-0.04	0.02	0.01-0.04

Adapted from Klein, J. O., and Finland, M.: New England J. Med., 269:1019, 1963.

with high blood levels, even in the presence of food



Adapted from Griffith, R. S., and Black, H. R.: Current Ther. Res., 6:253, 1964.

V-Cillin K® Lilly 700867

Potassium Phenoxymethyl Penicillin

(See next page for prescribing inform

New 500 mg. tablets...a more convenient way to give high doses



Description: V-Cillin K is the potassium salt of V-Cillin® (phenoxymethyl penicillin, Lilly). This chemically improved form combines acid stability with immediate solubility and rapid absorption. Higher serum levels are obtained more rapidly with this penicillin than with equal oral doses of penicillin G. The higher serum levels and acid stability of V-Cillin K make it a more dependable penicillin for oral use.

V-Cillin K, Pediatric, is an oral solution of clinically proved V-Cillin K in teaspoon dosage form. When mixed as directed, each 5 cc. (approximately one teaspoonful) will contain 125 mg. (200,000 units) phenoxymethyl penicillin as the potassium salt.

Indications: V-Cillin K has been shown to be effective in the treatment of streptococcus, pneumococcus, and gonococcus infections as well as infections caused by sensitive strains of staphylococci. It may be used for the prophylaxis of streptococcus infections in patients with a history of rheumatic fever and for the prevention of bacterial endocarditis after tonsillectomy and tooth extraction in those patients with a history of rheumatic fever or congenital heart disease.

Contraindication: V-Cillin K should not be administered to a patient with a history of penicillin hypersensitivity.

Warnings: In rare instances, the use of penicillin may cause acute anaphylaxis which may prove fatal unless promptly controlled. This type of reaction appears more frequently in patients with a history of sensitivity reactions to penicillin and in those with bronchial asthma or other allergies. Resuscitative drugs should be readily available for emergency administration. These include epinephrine and pressor drugs (as well as oxygen for inhalation) for relief of immediate allergic manifestations and antihistamines and corticosteroids for delayed effects.

Precautions: V-Cillin K should be used cautiously, if at all, in a patient with a strongly positive history of allergy.

In prolonged therapy with penicillin, and particularly with high parenteral dosage schedules, frequent evaluation of the renal and hematopoietic systems is recommended.

In suspected staphylococcus infections, proper laboratory studies (including sensitivity tests) should be performed.

The use of penicillin may be associated with the overgrowth of penicillin-insensitive organisms. In such cases, its administration should be discontinued, and appropriate measures should be taken.

Adverse Reactions: Although serious allergic reactions are much less common with administration of oral penicillin than with intramuscular forms, manifestations of penicillin allergy may occur.

Penicillin is a substance of low toxicity, but it does possess a significant index of sensitization. The following hypersensitivity reactions associated with the use of penicillin have been reported: skin rashes ranging from maculopapulor eruptions to exfoliative dermatitis, urticaria; and reactions resembling serum sickness, including chills, fever, edema, arthralgia, and prostration. Severe and often fatal anophylaxis has occurred (see Warnings). Hemolytic anemia, leukopenia, thrombocytopenia, and nephropathy are rarely observed side-effects and are usually associated with high parenteral dosage.

Administration and Dosage: For Tablets V-Cillin K and for V-Cillin K Pediatric, the usual dosage ranges from 125 mg. (200,000 units) three times a day to 500 mg. (800,000 units) every four hours. For infants the daily dosage may be 50 mg. per Kg. of body weight divided in three doses.

Beta-hemolytic streptococcus infections without associated bacteremia may be treated with 200,000 to 400,0000 units three times a day. Therapy should be continued for a minimum of ten days to prevent development of rheumotic fever and/or other serious complications. Dosage for routine streptococcus prophylaxis in patients with a history of rheumotic fever or congenital heart disease may be 200,000 units once or twice daily. When such patients undergo tonsillectomy, tooth extraction, or other minor surgery, the prophylactic dose should be 500,000 units every six hours given two days prior to surgery and for two days postoperatively. If oral medication is not feasible on the day of surgery, parenteral therapy should be considered. Mild to moderately severe pneumococcus pneumonia has been treated effectively with 250 mg. every six hours.

In staphylococcus infections, 400,000 units or more should be given every six to eight hours in conjunction with indicated surgical procedures.

For gonorrheo in moles, 500 mg. (800,000 units) every four hours for three doses may be employed; in females, 500 mg. every four hours for six doses are recommended. Refractory infections generally respond to a second treatment three to four days following completion of the first. Treatment of gonorrheo with severe complications should be individualized, with prolonged and intensive treatment. Patients with a suspected lesion of syphilis should have a dark-field examination before receiving penicillin and monthly serologic tests for a minimum of three months.

How Supplied: Tablets V-Cillin K, U.S.P., 125 mg. (200,000 units) in bottles of 50 and 100; and 250 mg. (400,0000 units) and 500 mg. (800,000 units), in bottles of 24 and 100.

V-Cillin K, Pediatric, for Oral Solution, 125 mg. (200,000 units) per 5 cc. of solution, in 40, 80, and 150-cc.-size packages. [032...

Additional information available to physicians upon request. Eli Lilly and Company, Indianapolis, Indiana 46206.

Lilly



50 Years Ago in the Journal

August 1917

Fifty years ago this month the following scientific articles appeared in the Journal: "Volkmann's Contracture," J. K. Simpson, M.D., Jacksonville; "The Advantages of the Proper Handling of Acute Appendicitis," Edward Jelks, M. D., Jacksonville; "The Indications and Abuse of Cesarean Section," F. J. Waas, M.D., Jacksonville; "The Sigmoid," Marvin H. Smith, M.D., Jacksonville; "Factors in Union and Use of Traction Suture Plates in Abdominal Incisions," R. R. Kime, M.D., Lakeland, and "The Food Value and Wholesomeness of Self-Rising Flour," H. O. Snow, M.D., Tampa.

Although most of the editorials in the issue dealt with various phases of the World War I situation, one was titled "End the Monopoly on Salvarsan." The lead editorial follows exactly as it appeared. It was signed "G.E.H." (Graham E. Henson, M.D. of Jacksonville, editor at that time).

THE NEEDS OF OUR NATION.

In spite of the publicity given by the press to the immediate needs of the United States Army for medical officers, the medical profession is largely holding back from making applications for appointments in the Medical Officers' Reserve Corps, seemingly taking the stand that the needs of the government are not immediate but can be looked upon as future possible needs. It is a rather deplorable fact that the younger men of the profession have not responded in anything like the ratio that the older ones have. The prominent men in the profession all over the country have responded in a wonderful manner and it is hard to understand why the younger and less prominent should falter. Since THE JOURNAL, under the caption "Selective Conscription for the Medical Reserve Corps of the Army," advocated the adoption of the selective draft system to secure medical officers, considerable agitation has sporadically appeared in various parts of the country in favor of this system. Up to the present time whether we care to admit it or not, the fact stares us in the face that the volunteer method of securing a sufficient number of medical officers for the care of our soldiers has failed. It is not yet too late to turn that failure into success. Surgeon General Gorgas emphasizes the point that in spite of the urgent needs of his department it is not desirable that physicians, whose departure from their homes would entail privation to the civilian population, make application for service, as after the candidate has once been commissioned it is not feasible to entertain applications for exemption from active duty. Certain sections of Florida have responded nobly to the Nation's call, certain others have as yet hardly been heard from. THE JOURNAL believes it to be the duty of every medical man under the age of forty, whose services can be spared from civilian life, to file at once his application for appointment in the Corps.

That the needs of the service are urgent is evident when it is recalled that a few weeks ago the Surgeon General stated that 20,000 physicians

were needed in the Medical Officers' Reserve Corps for the care of our Army. The Council on National Defense recently authorized the following: "Letters have been sent out to all the county committees and special inquiries have been started through the State Committees, medical section, Council of National Defense, in an effort to check up the medical men who have actually accepted commissions in the Medical Officers' Reserve Corps, and the reasons why commissions offered to others have not yet been accepted. Our records indicate that to date something like 11,000 commissions have been offered and that only approximately 5,000 have been accepted. Various general reasons why more commissions have not been accepted are known, but there doubtless exists in different sections of the country special difficulties which should be overcome, and the section is making an effort to determine the exact status of the matter."

G. E. H.

MEDICAL DEPARTMENT
—OF THE—
TULANE UNIVERSITY OF LOUISIANA.
(Formerly, 1847-1884, the University of Louisiana).

FACULTY.—T. G. Richardson, M. D., Prof. of Surgery; Stanford E. Chaillé, M. D., Prof. Physiology and Pathological Anatomy; Joseph Jones, M D., Prof. Chemistry; E. S. Lewis, M. D., Prof. Obstetrics and Diseases of Women and Children; J. B. Elliot, M. D., Prof. Practice of Medicine; J. F. Y. Paine, M.D., Prof. Materia Medica, Therapeutics and Hygiene; Edmond Souchon, M. D., Prof. Anatomy. Dr. S. D. Kennedy lectures on Diseases of the Eye and Ear and Dr. R. Matas is the Demonstrator of Anatomy. By law, exceptional advantages are given for practical instruction in the wards of the great Charity Hospital with its 700 beds, 8000 sick admitted and 10,000 outdoor patients. Fees for Lectures, $140. For circular or additional information, address:

S. E. CHAILLE, M. D., Dean,
P O. Drawer 261, New Orleans, La.

Reprinted from The New Orleans Medical and Surgical Journal, June 1887.

CINCINNATI SANITARIUM,



A PRIVATE HOSPITAL FOR THE INSANE. COLLEGE HILL, OHIO.

Twelve years successful operation. One hundred and fifty patients admitted annually. Daily average, sixty. Cottages for nervous invalids, opium habit, etc. Location salubrious. Surroundings delightful. Appliances ample. Charges reasonable. Accessible by rail. Six trains daily. Forty minutes from C. H. & D. Depot, Fifth and Hoadley Streets, Cincinnati.

For particulars address,
7 85-12t ORPHEUS EVERTS, M. D., Sup't, College Hill, Ohio.

Reprinted from The Atlanta Medical and Surgical Journal, September 1885.

Don't let monilia cut broad-spectrum therapy short...

start with Tetrex-F®

tetracycline phosphate complex-nystatin

Use of broad-spectrum antibiotics can cause fungal overgrowth in the alimentary tract... and give rise to symptoms so troublesome that therapy must be prematurely stopped. Tetrex-F (tetracycline phosphate complex-nystatin) helps you circumvent this problem.

The nystatin can prevent overgrowth of monilia; the phosphate complex delivers tetracycline to the blood rapidly. Side effects are infrequent.

High-Risk Patients

Tetrex-F (tetracycline phosphate complex-nystatin) is especially useful in patients most susceptible to fungal overgrowth during tetracycline therapy: (1) the elderly or debilitated, (2) young children, (3) the diabetic, (4) those on long-term tetracycline therapy, (5) those on steroid therapy, (6) those who have had moniliasis before, and (7) pregnant patients with a history of monilial vaginitis.

When you start with economical Tetrex-F (tetracycline phosphate complex-nystatin), you can complete the full course of broad-spectrum therapy with less chance of losing control elsewhere. A good start for a healthy finish.

PRESCRIBING INFORMATION. For complete information consult Official Package Circular. *Indications:* Infections of respiratory, gastrointestinal and genitourinary tracts and skin and soft tissues due to tetracycline-sensitive organisms, in patients with increased susceptibility to monilial infections. *Contraindications:* The drug is contraindicated in patients hypersensitive to its components. *Warnings:* Photodynamic reactions have been produced by tetracyclines. Natural and artificial sunlight should be avoided during therapy. Stop treatment if skin discomfort occurs. With renal impairment, systemic accumulation and hepatotoxicity may occur. In this situation, lower doses should be used. Tooth staining and enamel hypoplasia may be induced during tooth development (last trimester of pregnancy, neonatal period and childhood). *Precautions:* Bacterial superinfections may occur. Infants may develop increased intracranial pressure with bulging fontanels. In gonorrheal therapy, serologic tests for syphilis should be conducted initially and monthly for 3 months. *Adverse Reactions:* Glossitis, stomatitis, nausea, diarrhea, flatulence, proctitis, vaginitis, dermatitis, and allergic reactions may occur. *Usual Adult Dosage:* 1 capsule q.i.d. Continue for 10 days in Beta-hemolytic streptococcal infections. Administer one hour before or two hours after meals. *Supplied:* Capsules, bottles of 16 and 100. Each capsule contains tetracycline phosphate complex equivalent to 250 mg. tetracycline HCl activity and 250,000 units of nystatin. For Oral Suspension, 125 mg. tetracycline and 125,000 u. nystatin 5 ml., 60 ml. bottles.

BRISTOL

BRISTOL LABORATORIES
Division of Bristol-Myers Company
Syracuse, New York 13201

J. H. ZEILIN & CO.,



CHEMICAL AND MEDICAL PREFARATIONS

306 & 308 CHERRY STREET, PHILADELPHIA, U.S.A.

—PROPRIETORS OF—

DR. SIMMONS LIVER REGULATOR,

Dr. Simmons Renovator Pill, Dr. Simmons Fever and Ague Pills,

DARBYS PROPHYLACTIC FLUID,

Parrishs Chemical and Medical Preparations:

Compound Syrup of Phosphates, (Chemical Food,)

Glycerole of Hypophosphites, Propylamin Cordial,
Syrup of Hypophosphites, Dragees of Santonine.
Solution of Meconate of Morphia.

Our Remedies

Are guaranteed by this Stamp on top of each article. The letter Z entwined around the Mortar, Graduate and Spatula, with our motto, "Purissima et Optima," inscribed in the limbs of the Z. Look for it carefully, it is on every article of the Genuine, and also the Signature and Seal of J. H. ZEILIN & CO.



FOR SALE BY ALL DRUGGISTS.

Rprinted from The Regulator Diary or Pocket Companion for Everybody, J. H. Zeilin & Co., Philadelphia, 1886.

National and Regional Meetings in Florida

August

American Academy of Physical Medicine & Rehabilitation, Americana Hotel, Miami Beach, Aug. 27-Sept. 1.

American Association of Electromyography and Electrodiagnosis, Americana Hotel, Miami Beach, Aug. 27.

American Congress of Rehabilitation Medicine, Americana Hotel, Miami Beach, Aug. 27-Sept. 1.

September

American Society for Colposcopy and Colpomicroscopy, Americana Hotel, Miami Beach, Sept. 28-Oct. 3.

October

American Association of Public Health Physicians, Miami Beach, Oct. 23-27.

American College of Preventive Medicine, Fontainebleau Hotel, Miami Beach, Oct. 22-23.

American Orthotics and Prosthetics Association, Fontainebleau Hotel, Miami Beach, Oct. 7-11.

American Public Health Association, Fontainebleau Hotel, Miami Beach, Oct. 23-27.

American School Health Association, Miami, Oct. 21-26.

November

Gerontological Society, Princess Martha Hotel, St. Petersburg, Nov. 9-11.

American College of Preventive Medicine, Fontainebleau Hotel, Miami Beach, Nov. 10-14.

Southern Medical Association, Miami Beach, Nov. 13-16.

National Federation of Catholic Physicians' Guild, Miami, Nov. 9-11.

Management of Trauma and Disaster Medical Problems, Carillon Hotel, Miami Beach, Nov. 10-11.

Vaccine Virus,

PURE AND RELIABLE ANIMAL VACCINE LYMPH, FRESH DAILY.

LIBERAL TERMS. *SEND FOR CIRCULARS.*

10 Ivory Points, - - - double charged, $1.00
10 Quill slips (half quills), - " " 1.00

Orders by Mail or Telegraph Promptly Dispatched.

NEW ENGLAND VACCINE CO., Chelsea Station, Boston, Mass.

WM. C. CUTLER, M. D. J. S. FRISBIE, M. D.

Reprinted from The New Orleans Medical and Surgical Journal, June 1887.



Reprinted from The American Medical Digest, August 15, 1887.

DEPRESSION



NORPRAMIN®
(desipramine hydrochloride)

ANTIDEPRESSANT FOR RAPID IMPROVEMENT

At the recommended dosage level —initially, 150 mg. per day— gratifying remission of the signs and symptoms of depression typically begins in 2-5 days. Its specificity for depression, rapidity of action and usually mild side effects are significant reasons for prescribing NORPRAMIN (desipramine hydrochloride) in depression of any type . . . any degree of severity.

A few patients, sensitive to central nervous system stimulants may become restless as depression is lifted—in such cases dosage may be reduced or a tranquilizer added.

IN BRIEF:

INDICATIONS: In depression of any kind —neurotic and psychotic depressive reactions; manic-depressive or involutional psychotic reactions.

CONTRAINDICATIONS: Glaucoma, urethral or ureteral spasm, recent myocardial infarction, severe coronary heart disease, epilepsy. Should not be given within two weeks of treatment with a monoamine oxidase inhibitor.

RELATIVE CONTRAINDICATIONS: (1) Patients with a history of paroxysmal tachycardia. (2) Patients receiving concomitant therapy with thyroid, anticholinergics or sympathomimetics may experience potentiation of effects of these drugs. (3) Safety in pregnancy has not been established.

PRECAUTIONS: (1) Outpatient use of desipramine hydrochloride should not be substituted for hospitalization when risk of suicide or homicide is considered grave. (2) If serious adverse effects occur, reduce dosage or alter treatment. (3) In patients with manic-depressive illness a hypomanic state may be induced. (4) Discontinue drug as soon as possible prior to elective surgery.

ADVERSE EFFECTS: Side effects, usually mild, may include: dry mouth, constipation, dizziness, palpitation, delayed urination, "bad taste," sensory illusion, tinnitus, anxiety, agitation and stimulation, insomnia, sweating, drowsiness, headache, orthostatic hypotension, flushing, nausea, cramps, weakness, blurred vision and mydriasis, rash, tremor, allergy, agranulocytosis, altered liver function, ataxia, and extrapyramidal signs.

DOSAGE: Optimal results are obtained at a dosage of 50 mg., t.i.d. (150 mg./day). **SUPPLIED:** NORPRAMIN (desipramine hydrochloride) tablets of 25 mg.; bottles of 50, 500 and 1000; and tablets of 50 mg., in bottles of 30, 250 and 1000.

LAKESIDE

LAKESIDE LABORATORIES, INC., Milwaukee, Wisconsin 53201



Special Article

On Being Fifty

LUDD M. SPIVEY, D.D.

Editor's Note: At a banquet in Tampa in 1940 honoring him on his fiftieth birthday, the late Dr. Ludd M. Spivey, for many years president of Florida Southern College, Lakeland, made the address presented here.

T.M.

This business of being fifty is no small affair. Admittedly, it is a common affair, for millions of men and women have had the experience. It is, however, a new adventure for me, and I should be stating less than the truth if I gave the impression that I came to terms with this matter without perturbations. I do not mean that I have lost much sleep on account of it, but I must confess that a terrific struggle has gone on in my coming to terms with it.

I have known all along, of course, that if I stayed alive I should have to meet it. But I didn't expect to meet it so soon. Besides, I purposely refused to note its approach. One always neglects to see, hear and think about what is bad to him.

But the time came when I had to take notice of it, for it was just in front of me. When I did look up I was greatly surprised. I did not find what I expected. Fifty greeted me cordially. I put out my hand coldly, half-heartedly.

"Evidently you don't know who I am," said this uninvited guest.

"To my great sorrow I do know who you are. Your name is Fifty. Your reputation has preceded you. But I must confess that you are better looking than I expected."

"You are wholly mistaken about my name. It is not Fifty. Someone has misinformed you."

"What is your name if it isn't Fifty?" I cried.

"My name is Legion," he replied.

"Surely, you are not related in any way to the Legion in the Bible, are you?"

"Oh, No! Calm your fears!"

"Then, why do you call yourself Legion?"

"Because I have a multitude of names."

"For instance, what is one of them?"

"Experience."

"Do you mean to say your name is Experience?"

"Sure!"

"Well, I have met you before, haven't I?"

"Oh, yes; but I am different now. I am taller, broader, stronger."

"Do you mean to say you are taller, broader and stronger than Forty?"

"Much more. I am all that Forty was and more. I can see more clearly, feel more deeply and think more accurately."

"Well, this is all new to me."

"I have another name, too."

"What is it?"

"Sense."

"You don't mean your name is Sense?"

"Surely."

"I am dumbfounded. I have been looking everywhere for you for years. And to think I have been trying my best to avoid you!"

"Don't get too enthusiastic!" said my newly made acquaintance. "We live in a world where things are not recognized for what they are. Keep in mind what others have told you about me."

"Why, do you know about the names the young men and young women are calling you? They call you "Born Too Early" and "Old Fogey," and though they don't say it out loud, many of them think you are just a plain fool."

"I know it. For a long time I have tried to tell them differently, but they couldn't hear me. It worried me no little, for I thought they purposely misunderstood me. One day when I was fretting and fuming because they persisted in their ignorance of me, I suddenly learned that one does not understand with his brain, nor hear with his ears. He hears with sense. How could they hear when they had nothing with which to hear?"

"Do you mean to tell me that I cannot share with those who are younger this great experience of meeting you?"

"Exactly."

"Well, do you have still another name?"

"Yes. Maturity."

"You don't mean ripeness, do you?"

"No. I mean steadfastness, surety, attachment, stability. And I have still another name."

"Tell me about it. I am deeply interested."

"My name is Life—Life at its best. I am Life intensified. I am Life with open eyes, clear mind, sensitive soul. I am Life abundantly, venturesomely."

"Whatever your name is, I am glad to make your acquaintance. And, though you may not believe it, I am sorry to leave you."

"Which way are you going?"

"Up this highway before me."

"That's my direction, too. By your side I shall make the journey with you. Where you go I shall go, and where you lodge I shall lodge."

Meetings

Approved by FMA
Committee on Postgraduate Education

August

6- 9 Alcoholic Rehabilitation Program. Fifth Annual Florida School of Alcohol Workshop, Lucerne Hotel, Miami Beach.

17-19 Postgraduate Obstetric-Pediatric Seminar, Daytona Plaza Hotel, Daytona Beach.

September

16-17 Sixth Annual Physician's Seminar on Respiratory Diseases, Hotel Robert Meyer, Jacksonville.

22-23 Cardiovascular-Radiology Seminar, J. Hillis Miller Health Center, Gainesville.

October

21 Duval County Medical Society, Seminar on Shock, Hotel Roosevelt, Jacksonville.

26-28 Today's Hospital Problems: An Interdisciplinary Approach, Tides Hotel and Bath Club, Redington Beach.

27-28 Infectious Diseases Seminar, J. Hillis Miller Health Center, Gainesville.

November

13-17 Selected Topics in Cardiology, Mt. Sinai Hospital of Greater Miami Auditorium, Miami Beach.

16-17 Obstetrics & Gynecology Seminar, J. Hillis Miller Health Center, Gainesville.

December

14-16 Modern Concepts in Surgery and Management of the Lower Extremity Amputee, Americana Hotel, Miami Beach.

January

4- 7 Recent Advances in Local Anesthetics and Regional Anesthesia, Eden Roc Hotel, Miami Beach.

24-25 Obstetrics & Gynecology Seminar, J. Hillis Miller Health Center, Gainesville.

Jan. 28-Feb 1—Infectious Disease in Children, Deauville Hotel, Miami Beach.

March

2 Current Medical Concepts, Watson Clinic, Lakeland.

THE DUVALL HOME for RETARDED CHILDREN

A home offering the finest custodial care with a happy home-like environment. We specialize in the care of infants, bed-ridden children and Mongoloids.

For further information write to

MRS. A. H. DUVALL GLENWOOD, FLORIDA

HOW LIKE IS "LIKE"?

Lately, you have been urged to use a semi-synthetic penicillin as though it were a broad-spectrum antibiotic.

Should you? In the face of the fact that the Council on Drugs of the American Medical Association has for some time advised against it?[1] And now the new (1967) United States Dispensatory says much the same thing, in even stronger terms—that the drug in question is neither a broad-spectrum antibiotic in the sense that the tetracyclines are, nor is it even the first penicillin with a wider range of antibacterial action.[2]

Should you, for example, in treating pneumonia? The rationale for using this penicillin in pneumonia is that it is effective against *Hemophilus influenzae* as well as against *Diplococcus pneumoniae*.

So, be it noted, is DECLOMYCIN.

But what about *Mycoplasma pneumoniae*, which may be better known to you as Eaton Agent? No penicillin is known to be effective against this common cause of pneumonia. DECLOMYCIN is.

Some believe that *Mycoplasma pneumoniae* may be responsible for upwards of 30 per cent of all cases of pneumonia.[3] Could this mean that if you employ a penicillin in pneumonia when the etiological agent is unknown, there may be an automatic 30 per cent chance of failure?

When you consider using a drug *like* a broad-spectrum antibiotic, why not use a *true* broad-spectrum antibiotic? Like DECLOMYCIN.

References: 1. A.M.A. Council on Drugs: *New Drugs* 1966 ed. Chicago: American Medical Association, p. 12. 2. Osol, A.; Pratt, R., and Altschule, M.D.: *The United States Dispensatory*, 26th ed. Philadelphia: J. B. Lippincott Co., 1967, p. 844. 3. Purcell, R. H., and Chanock, R. M.: Role of Mycoplasmas in Human Respiratory Disease. *Med. Clin. N. Amer.* 51:791 (May) 1967.

DECLOMYCIN®
DEMETHYLCHLORTETRACYCLINE

Lederle

Prescribing information on next page.

For a wide range of everyday infections—respiratory, urinary tract and others—in the young and aged—the acutely or chronically ill.

TRUE BROAD SPECTRUM

DECLOMYCIN Demethylchlortetracycline should be equally or more effective than other tetracyclines when the offending organisms are tetracycline-sensitive.

Contraindication: History of hypersensitivity to demethylchlortetracycline.

Warning—In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated, and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort. Necessary subsequent courses of treatment with tetracyclines should be carefully observed.

Precautions—Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects—Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes. A rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney—rise in BUN, apparently dose related. Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth — dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs discontinue medication and institute appropriate therapy.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

Capsules: 150 mg; **Tablets:** film coated, 300 mg, 150 mg, and 75 mg of demethylchlortetracycline HCl.

DECLOMYCIN®
DEMETHYLCHLORTETRACYCLINE

LEDERLE LABORATORIES, A Division of
American Cyanamid Company, Pearl River, New York

Lederle

453-7—4951



The Medical Delective

Hazards of the Convention-Goer

Frequently we are confronted with diagnostic problems and unexpected findings associated with trauma which may have occurred while the patient has been under the influence of alcohol. The patient may not even remember the trauma, or it may have occurred with such a minor degree of discomfort that it was completely overlooked and forgotten. Unexpected trauma may occur in persons participating in sports, possibly on a picnic where an unusual amount of beer or alcohol is consumed, during school play and also to the alcoholic, where additional problems of clotting and cerebral atrophy may be interjected.

One such case involved a prominent out of town business executive, age 45, who was admitted to the hospital one morning after having been found in his hotel room in extreme pain and shock. The patient had a history of a peptic ulcer and had been treated for bleeding on one occasion several months before. On the evening prior to his admission, he had attended a convention cocktail party where he had consumed numerous cocktails in addition to the food. There was a history of moderate alcohol imbibition over the past several years. During the week of the convention, he averaged over one pint of whisky per day.

On admission he was in shock and writhing in pain. The abdomen was distended, tense, tympanitic and tender. X-rays revealed a pneumoperitoneum and an exploratory laparotomy was performed with a preoperative diagnosis of a perforated ulcer. The peritoneal cavity was full of intestinal contents and gas. No ulcer was found. The search disclosed a one inch linear tear in the ileum. This was repaired, but the patient died in shock eight hours later.

The postmortem examination revealed no evidence of tumor or inflammatory disease to account for the rupture. There was some bleeding in the mesentery and retroperitoneally. External trauma was present only in a small area of ecchymosis to the right of the rectus muscle at the level of the umbilicus.

In questioning friends, it was discovered the victim had fallen against a chair as he was being led back to his hotel room after the cocktail party.

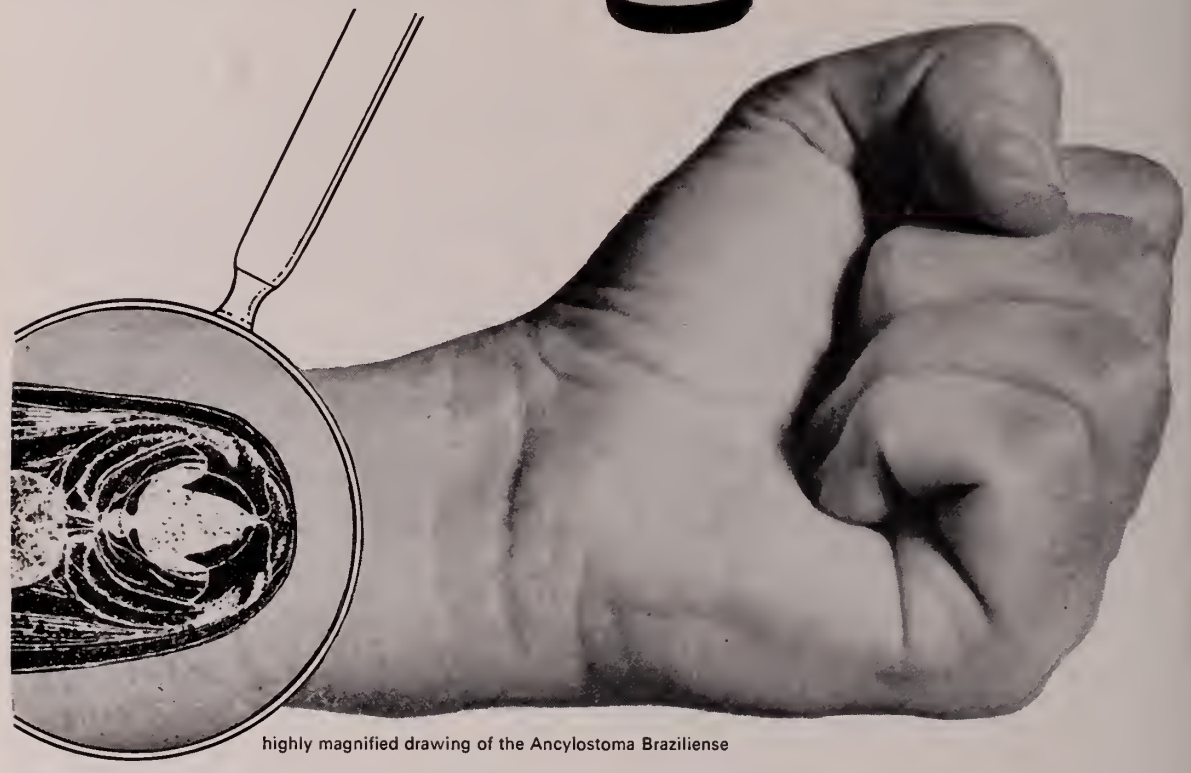
On occasion, unexpected trauma is discovered during the investigation of a sudden death. It is associated not infrequently with direct trauma to the abdomen in which there is distention of the viscera and a direct nonpenetrating injury is concentrated to one point in the abdominal wall. Such injury may or may not be associated with external evidence of trauma, and it may result in death before any medical treatment or attention is rendered.

The autopsy was of extreme importance to the widow, since the deceased held a double indemnity life insurance policy.

William G. Eckert, M.D.

Gebauer's Ethyl Chloride stops creeping eruption cold





highly magnified drawing of the Ancylostoma Braziliense

Creeping eruption is ugly, uncomfortable, and persistent. And, in Florida, it is seen with considerable frequency.

Creeping eruption is caused by the larvae of the dog and cat hookworm, *Ancylostoma Braziliense*. The larvae of this parasite burrow between the superficial layers of the skin, causing much discomfort and characteristic angry eruptions.

Happily, Gebauer Ethyl Chloride sprayed on the affected area for 30 seconds to one minute will usually kill the offending larvae. In difficult cases, it may be necessary to spray for a period of up to two minutes. Improvement and cure generally follow a comparatively few applications.

Next time you treat creeping eruption, treat it with Gebauer Ethyl Chloride. Also highly effective as a topical anesthetic for minor surgery, as in removal of splinters, incision of boils and whitlows, and to alleviate needle pain. May be used for relief of pain such as first and second degree burns, bee stings, sprains and muscle spasm.

GEBAUER PRODUCTS AVAILABLE AT

CORAL GABLES: Surgical Equipment Co. JACKSONVILLE: Central Medical & Surgical Supply • Hermax Corporation • Medical Supply Co. of Jacksonville • Surgical Supply Co. MIAMI: Amedic Surgical Co. • Florida Physicians Supply • Medical Supply Co. ORLANDO: Anderson Surgical Supply Co. • Medical Supply Co. ST. PETERSBURG: Anderson Surgical Supply Co. SARASOTA: Anderson Surgical Supply Co. TALLAHASSEE: Southeastern Surgical Supply Co. TAMPA: Anderson Surgical Supply Co. • Medical Supply Co. • Southern Surgical Supply Co. • Surgical Equipment Co. of Florida. WEST PALM BEACH: Medical Associates Corp. • Medical Supply Co.

OR YOUR LOCAL PHARMACY

Gebauer's

GEBAUER CHEMICAL COMPANY

9410 St. Catherine Ave. • Cleveland, Ohio 44104

APPALACHIAN HALL

ASHEVILLE Established 1916 NORTH CAROLINA



An Institution for the diagnosis and treatment of Psychiatric and Neurological illnesses, rest, convalescence, drug and alcohol habituation.

Insulin Coma, Electroshock and Psychotherapy are employed. The Institution is equipped with complete laboratory facilities including electroencephalography and X-ray.

Appalachian Hall is located in Asheville, North Carolina, a resort town, which justly claims an all around climate for health and comfort. There are ample facilities for classification of patients, rooms single or en suite.

Wm. Ray Griffin Jr., M.D.
Robert A. Griffin, M.D.

Mark A. Griffin Sr., M.D.
Mark A. Griffin Jr., M.D.

TUCKER HOSPITAL, INC.

212 West Franklin Street

Richmond, Virginia

A private hospital for diagnosis and treatment of psychiatric and neurological disorders. Hospital and out-patient services.

James Asa Shield, M.D.
George S. Fultz, Jr., M.D.
Catherine T. Ray, M.D.

Weir M. Tucker, M.D.
Edward W. Gamble, III, M.D.
Gerald W. Atkinson, M.D.

Woman's Auxiliary Wins HEW Award

Outstanding work in training citizens in disaster preparedness won a Department of Health, Education, and Welfare Division of Health Mobilization award for the Woman's Auxiliary to the Robeson County Medical Society, of North Carolina.

The award was presented Wednesday, June 21, during the 44th annual convention of the Woman's Auxiliary to the American Medical Association in Atlantic City, New Jersey.

Having laid the groundwork the previous year, the Robeson County auxiliary launched a series of classes, taught by trained professional personnel, designed to acquaint citizens with methods of medical self-help for disaster circumstances.

Three county auxiliaries receiving honorable mention in the award competition were Pinellas County, Fla., which worked to acquaint the community with various auxiliary-based activities including the Block Mother Program, homemaker service and health education; Bexar County, Tex., which coordinated the efforts of safety organizations by sponsoring a safety conference for youth; and the Utah state auxiliary, which sponsored a 16-point program covering various things including disaster drills in hospitals, immunization programs, "treatment for shock" classes, and transportation of victims from a scene of disaster.

World Medical Association Membership Open

Individual membership in The World Medical Association is now open to all members of the American Medical Association.

Dues are $10 per year. This includes a subscription to World Medical Journal and the privilege of participation in the World Medical Assembly each year.

The 21st World Medical Assembly will be held in Madrid, Spain, September 10-17, 1967. The 1968 Assembly will be held in Australia.

The World Medical Association is a society of the free, professional medical associations of the free nations. Sixty national medical associations are members, including the AMA.

The 20th World Medical Assembly last winter in Manila created for the first time an individual associate membership within the WMA. Members of the national medical associations may now join WMA as individuals.

Gerald D. Dorman, M.D., of New York City, member of the AMA's Board of Trustees, is Chairman of the Council, governing body of the WMA. The WMA Headquarters Secretariat is located at 10 Columbus Circle, New York City. Secretary General is Alberto Z. Romualdez, M.D.

Application for individual membership may be made to WMA at the New York City office. Applications should be accompanied by a check for $10, with a statement that the applicant is a member in good standing of AMA. The letter should specify whether the applicant wishes to receive the *World Medical Journal* in the English, Spanish or French language edition. Checks should be made payable to The World Medical Association, Inc., a tax-exempt organization. Five-year memberships are available for $50. Information regarding the 21st World Medical Assembly will be mailed promptly to all applicants for individual membership.



"George wants to know if it's okay to take his cold medicine now, Doctor, instead of seven o'clock?"

The long-continued action of Novahistine LP should help you both get a good night's sleep. Two tablets in the morning and two in the evening will usually provide round-the-clock relief by helping clear congested air passages for freer breathing. Novahistine LP also helps restore normal mucus secretion and ciliary activity—normal physiologic defenses against infection of the respiratory tract. Use cautiously in individuals with severe hypertension, diabetes mellitus, hyperthyroidism or urinary retention. Caution ambulatory patients that drowsiness may result. Each Novahistine LP tablet contains: phenylephrine hydrochloride, 25 mg., and chlorpheniramine maleate, 4 mg.

NOVAHISTINE® LP

DOW **PITMAN-MOORE** Division of The Dow Chemical Company, Indianapolis

CONVENTION PRESS

2111 NORTH LIBERTY ST.
JACKSONVILLE, FLORIDA
32206

QUALITY BOOK PRINTING
PUBLICATIONS BROCHURES

WHATEVER your first requisites may be, we always endeavor to maintain a standard of quality in keeping with our reputation for fine work —and at the same time provide the service desired. Let CONVENTION PRESS help solve your printing problems by intelligently assisting on all details.

Anderson Surgical Supply Co.

Established 1916

Distributors of Known Brands of Proven Quality

TELEPHONE 229-8504
Morgan at Platt, P. O. Box 1228
TAMPA, FLORIDA 33601

TELEPHONE 896-3107
556 9th St., South
ST. PETERSBURG, FLORIDA

TELEPHONE 376-8253
236 S.W. 4th Ave.
GAINESVILLE, FLORIDA

TELEPHONE CHerry 1-9589
1818 N. Orange Ave.
ORLANDO, FLORIDA

Hill Crest
HOSPITAL

(Formerly Hill Crest Sanitarium)

7000 5TH AVENUE SOUTH
Box 2896, Woodlawn Station
Birmingham, Alabama 35212
Phone: 205 - 836-7201

A patient centered independent hospital for intensive treatment of nervous disorders . . .

Hill Crest Hospital was established in 1925 as Hill Crest Sanitarium to provide private psychiatric treatment of nervous or mental disorders. Individual patient care has been the theme during its 42 years of service.

Both male and female patients are accepted and departmentalized care is provided according to sex and the degree of illness.

In addition to the psychiatric staff, consultants are available in all medical specialities.



MEDICAL DIRECTOR:
James A. Becton, M.D., F.A.P.A.

CLINICAL DIRECTORS:
James K. Ward, M.D., F.A.P.A.
Hardin M. Ritchey, M.D., F.A.P.A.

HILL CREST is a member of:
AMERICAN HOSPITAL ASSOCIATION NATIONAL ASSOCIATION OF PRIVATE PSYCHIATRIC HOSPITALS . . . ALABAMA HOSPITAL ASSOCIATION . . . BIRMINGHAM REGIONAL HOSPITAL COUNCIL.
Hill Crest is fully accredited by the Joint Commission on Accreditation of Hospitals.

Hill Crest
HOSPITAL
BIRMINGHAM, ALABAMA



Ballast Point Manor

5226 Nichols St., P. O. Box 13467 Phone 831-4191
Tampa, Florida

Don Savage, Owner-Manager

Care of mild mental cases, senile disorders and invalids. Alcoholics treated. Aged adjudged cases will be accepted on either permanent or temporary basis.

Thomas B. Slade — Fifty Years in Florida — J. Beatty Williams

Surgical SUPPLY COMPANY

HAMILTON — RITTER — SKLAR — BURDICK
CLAY-ADAMS — B-D — BARD-PARKER — TYCOS
BAUM — WELCH-ALLYN AND MANY, MANY OTHERS

Ph. 355-8391 P. O. Box 2580 — 1050 W. Adams Street Jacksonville, Fla. 32203



P. L. DODGE MEMORIAL HOSPITAL

M. G. Isaacson, M.D.
Medical Director
1861 N.W. South River Drive
Miami, Florida
Phone 379-1448

A nonprofit-voluntary hospital for the treatment of nervous and mental disorders and the problems of drug addiction and alcoholic habituation. Modern diagnostic and treatment procedures including—Psychotherapy, Insulin, & Electroshock, when indicated. Adequate facilities for recreation and out-door activities. Admissions are made without regard to race, color or national origin.

Information on request

Member NAPPH, American Psychiatric Assn., & American Hospital Assn.



The meaningful pause. The energy it gives. The bright little lift. Coca-Cola with its never too sweet taste, refreshes best. Helps people meet the stress of the busy hours. This is why we say **things go better with Coke**
TRADE-MARK

HIGHLAND HOSPITAL

ASHEVILLE, NORTH CAROLINA

Founded 1904

A DIVISION OF THE DEPARTMENT OF PSYCHIATRY
OF DUKE UNIVERSITY

Accredited by the Joint Commission on Accreditation and Certified for Medicare

Complete facilities for evaluation of and intensive treatment of psychiatric patients, including individual psychotherapy, group therapy, psychodrama, electro-convulsive therapy, Indoklon convulsive therapy, drugs, social service work with families, family therapy, and an extensive and well organized activities program, including occupational therapy, art therapy, athletic activities and games, recreational activities and outings. The treatment program of each patient is carefully supervised in order that the therapeutic needs of each patient may be realized.

Complete modern facilities with 85 acres of landscaped and wooded grounds in the City of Asheville.

Brochures and information on financial arrangements available
Contact: Mrs. Elizabeth Harkins, ACSW, Coordinator of Admissions

or

Charles W. Neville, Jr., M.D.
Assistant Professor of Psychiatry and Medical Director
Area Code 704 - 253-2761



When relief means so much in keeping your G.U. patient comfortable **URISED®**

CONAL PHARMACEUTICALS INC

Clinically effective for G.U. Therapy[1-5]

There are not many drug combinations in use today which can claim to have served the medical profession for more than 50 years. Such a record reflects the continued confidence of physicians in URISED. This is not a dramatic "wonder drug"—but a *useful* one.

It fills a need in urologic and general practice—a need for a mild but reliable agent with a very low order of toxicity. It can be used alone to treat mild and uncomplicated urinary infections. It can be used as "interim therapy" while awaiting the results of urine culture. It can be used as an adjunct (to relieve pain and spasm) with almost any other form of antibacterial therapy.

The characteristic blue/green urine tells the patient that something is happening. The patient generally tells you that symptomatic relief follows the first dose.

REFERENCES: (1) Sands, R.X.: New York St. J. Med. 61:2598-2602, 1961; (2) Renner, M.J., et al.: Hosp. Topics 39:71-73, 1961; (3) Haas, Jr., J., and Kay, L. L.: Southwest Med. 42:30-32,1961; (4) Marshall, W.: Clin. Med. 7:499-502, 1960; (5) Strauss B.: Clin. Med. 4:307-310, 1957.

URISED®

Each Blue-Coated Tablet contains Active:

Atropine Sulfate	0.03 mg.	Methylene Blue	5.4 mg.
Hyoscyamine	0.03 mg.	Phenyl Salicylate	18.1 mg.
Methanamine	40.8 mg.	Benzoic Acid	4.5 mg.

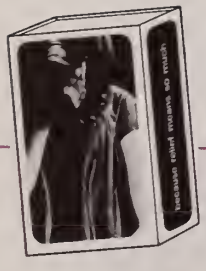
PRECAUTIONS: Administer with caution to persons with atropine idiosyncrasy or cardiac disease.

SIDE EFFECTS: Neither irritation nor untoward reactions have been reported; however, if pronounced dryness of the mouth, flushing, or difficulty in initiating micturition occur, decrease dosage. If rapid pulse, dizziness or blurring of vision occur, discontinue use immediately. Acute urinary retention may be precipitated in prostatic hypertrophy.

CONTRAINDICATIONS: Glaucoma, urinary bladder neck or pyloric obstruction, duodenal obstruction and cardiospasm. Hypersensitivity to any of the ingredients.

DOSAGE: Adults—Two tablets, orally, four times per day followed by liberal fluid intake. Acute cases—initially two tablets every hour for three doses followed by the recommended daily administration. Children—One-half the adult dose.

(Stocked *Nationally Through All Service Wholesale Druggists*)



CONAL
PHARMACEUTICALS, INC
CHICAGO, ILLINOIS 60640

MANUFACTURERS OF URICEUTICAL® SPECIALTIES

• CYSTOSPAZ® • URISEDAMINE® • ŪTRASUL® Tablets and Suspension

PRINTED IN U.S.A.

FEB 1967

When the problem is only skin deep

USE 'POLYSPORIN'® brand POLYMYXIN B-BACITRACIN OINTMENT

for topical antibiotic therapy with minimum risk of sensitization

Caution: As with other antibiotic products, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

Supplied in ½ oz. and 1 oz. tubes.

Complete literature available on request from Professional Services Dept. PML.

BURROUGHS WELLCOME & CO. (U.S.A.) INC.
Tuckahoe, N.Y.



A COMPLETE BUSINESS SERVICE

FOR THE MEDICAL AND DENTAL PROFESSIONS

Professional Management

PM FLORIDA

233 Fourth Ave, N.E.
St. Petersburg, Florida
Phone 898-5074

1855 Hillview Street
Sarasota, Florida
Sarasota Phone 958-4493
4771 Bilmark
Ft. Myers, Florida
Ft. Myers Phone 936-3162

417 Executive Building
1175 N.E. 125th St.
Miami, Florida 33125
Dade Phone 751-2101
Broward Phone 523-0286

PROFESSIONAL MANAGEMENT since 1932 PM FOR PHYSICIANS AND DENTISTS

Affiliates of Black & Skaggs Associates
Battle Creek, Michigan

YOUR Patronage Has Made Our Growth Possible

Medical Supply Company of Jacksonville



Home Office

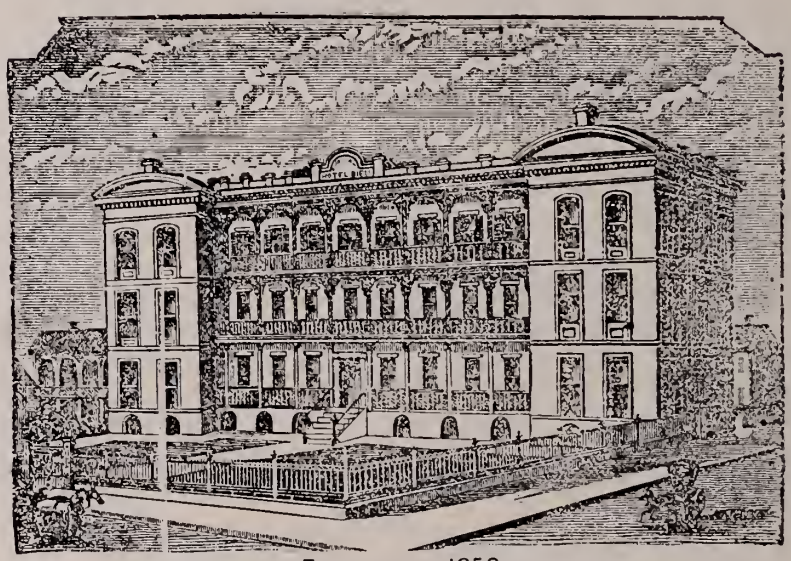
JACKSONVILLE
4539 Beach Blvd.
Telephone FL 9-2191

ORLANDO
1511 Sligh Blvd.
Telephone GA 5-3537

HOTEL DIEU,

THE INFIRMARY OF THE SISTERS OF CHARITY,

NEW ORLEANS, LA.



FOUNDED IN 1859.

Situated on COMMON STREET, between BERTRAND and JOHNSON.

The Canal and Common Street Cars pass in front of the door.

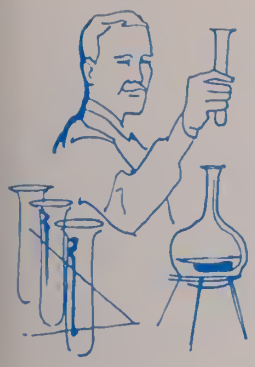
The Hotel Dieu is a private hospital or infirmary, under the care of the Sisters of Charity. The rooms are comfortably and neatly furnished, and patients live as privately as they desire. Meals are served in the rooms without extra charge. The wards for men, and also those for women, are large and well ventilated, offering comfortable accommodations, at a moderate cost, to persons occupying the same room. Meals to ward patients are served separately.

The building has recently been thoroughly repaired, and the household furniture entirely renovated. To the sick and injured are offered the conveniences of a modern hospital; to the incurable and infirm, a comfortable home. The institution is under the general management of the Sisters of Charity, and the inmates under their special care and protection. The Physician in Charge visits the house twice daily, morning and afternoon.

TERMS:—Private Rooms, per day, $2 00 to $5 00; Beds in wards, $1.00 per day. These terms include board and lodging, nursing, medicines, etc., and the attendance of the Physician in Charge, (except in the more important surgical cases). Patients, at their own expense, may employ any other physician of good standing.

For further information address the Sister Superior, or the Physician in Charge, Hotel Dieu, New Orleans, La.

Reprinted from The New Orleans Medical and Surgical Journal, June 1887.



Public Health Topics

Screening for Glaucoma

Don Adams was 32 years old, energetic, ambitious, and managed the Lakeland branch of a large national retailing organization. In addition to other civic responsibilities, he held membership in a Lions Club cooperating in an extensive and continuous program of screening for glaucoma in Polk County. His particular club was helping kick off the program, and arrangements had been made for all members to be screened at a regular weekly meeting.

Under the supervision of an ophthalmologist, an anesthetic, proparacaine, was instilled in each eye and after a few seconds the pressure of the eyeball was measured by placing a tonometer on the cornea. An intraocular pressure of more than 40 mm. Hg in each eye was registered. At Don Adams' age, the odds against such increased pressure were very great. For this detection program, the Florida Society of Ophthalmology and Otolaryngology had decided that a reading of 25.8 mm. Hg or a difference in pressure between the eyes of 6 mm. Hg or more would be the level at which further diagnostic procedures should be recommended. Upon this basis, he was advised to consult an ophthalmologist, and a referral card was provided.

Subsequently, the diagnosis of bilateral chronic angle closure glaucoma was established, a type often permanently cured with adequate surgical procedures. Some weeks later, Don Adams entered the hospital and a therapeutic "buttonhole" iridectomy in the base of each iris was performed. This resulted in the pressure of each eye being reduced to 19 mm. Hg. Fortunately, in this case, it will remain within normal limits and drops will not be necessary. As far as his vision is concerned, it has been saved, permitting some 30 or 40 more years of active life for this promising business executive. The saving of Don Adams' sight was the first reward for the initial weeks of screening. He is a real person; the name is fictitious.

The first glaucoma detection clinic in Florida, known as the Polk County Eye Clinic, was established at Lakeland General Hospital with the full cooperation and assistance of local ophthalmologists. They supervise the clinic and direct the entire screening program. Actual testing is done by a registered nurse, especially instructed in the procedure, five days a week throughout the year. She is assisted in the clinic by trained volunteers. All persons over 21 years of age, regardless of financial status, are eligible for screening with the exception of those with known glaucoma. The fact that the test is for glaucoma only and does not replace a complete eye examination is stressed. All patients with ocular tension in the suspicious range are referred to ophthalmologists. It is measured with a Schiotz tonometer using the 7.5 Gm. weight.

In the past five years more than 47,000 persons have been screened in the Polk County Eye Clinic. Of this number more than 1,100 have been referred to ophthalmologists for further diagnostic procedures. About 700 cases have a definitive diagnosis of glaucoma and records in the clinic indicate that these patients are receiving treatment. As a result, most of them will have a useful vision for many years.

The screening program in Polk County is a cooperative endeavor among the county ophthalmologists and several community organizations. The Lions Clubs, Lions Foundation and the Florida Council for the Blind have provided volunteers and funds for equipment. The National Institutes of Health, through the U. S. Public Health Service, and the Florida State Board of Health, furnished a major share of the funds needed to get the clinic started. The Polk County commissioners are providing quarters and utilities. At the present time, most of the financial support comes from the three United Fund organizations that operate throughout the county.

The seed planted in Polk County has sprouted and grown elsewhere. There are now similar continuous glaucoma detection programs in Volusia, Broward, Pinellas and Duval counties. Two of the clinics are hospital-oriented; the others are located in the health departments.

In the Volusia, Broward, Pinellas and Polk programs, 113,174 persons had been screened at the end of March 1967, and 2,755 referred to ophthalmologists for further diagnosis. Of this number, 1,510 were found to have glaucoma or borderline glaucoma. The findings in Duval County are not included since screening there has been conducted principally on the indigent people served by the outpatient clinic of a county hospital and on those patients referred to the eye clinic.

In detection clinics and in office practice, glaucoma in some patients may be missed. This possibility is due to the peculiar characteristics of the disease. But it is well to keep in mind that screening procedures properly utilized do detect a high percentage of the unknown glaucoma that otherwise might not have been detected until the late stages of the disease.

Marion W. Hester, M.D.
Lakeland



Reprinted from The New Orleans Medical and Surgical Journal, June 1887.

Night Leg Cramps . . . Unwelcome Bedfellow

In Diabetes[1], Arthritis[2], and Peripheral Vascular Disorders[2]



now . . . specific therapy for night leg cramps

Walker

QUINAMM™

Consistently effective, QUINAMM provided complete relief in 94% of 200 patients studied, many of whom were severe cases refractory to other medication.[3] Your prescription for one tablet at bedtime often controls painful night cramps with the initial dose . . . helps restore restful sleep.

THE NATIONAL DRUG COMPANY
DIVISION OF RICHARDSON MERRELL INC
PHILADELPHIA, PENNSYLVANIA 19144

Prescribing Information: Composition: Each white, beveled, compressed tablet contains: Quinine Sulfate 260 mg. and Aminophylline 195 mg. **Contraindication:** QUINAMM is contraindicated in pregnancy because of its quinine content. **Precautions:** Aminophylline may produce intestinal cramps in some instances, and quinine may produce symptoms of cinchonism, such as tinnitus, dizziness, and gastrointestinal disturbance. Discontinue use if ringing in the ears, deafness, skin rash, or visual disturbances occur. **Dosage:** One tablet upon retiring. Where necessary, dosage may be increased to one tablet following the evening meal and one tablet upon retiring. **Supplied:** Bottles of 100 and 500 tablets.

References: 1. Shuman, C.: Am. J. Med. Sci., 225:54, 1953. 2. Perchuk, E., et al.: Angiology, 12:102, 1961. 3. Rowls, W., et al.: Med. Times, 87:818, 1959.

6/67 Q-706A



in alcoholism:

B and C vitamins aid therapy. Therapeutic amounts of B and C vitamins ca be important in the management of the alcoholic patient. In alcoholism, as many chronic illnesses, STRESSCAPS vitamins aid therapy.



Stresscaps®

Stress Formula Vitamins Lederle

FOR PROFESSIONAL RECOMMENDATION ONLY

Each capsule contains:

Vitamin B_1 (as Thiamine Mononitrate)	10 mg
Vitamin B_2 (Riboflavin)	10 mg
Vitamin B_6 (Pyridoxine HCl)	2 mg
Vitamin B_{12} Crystalline	4 mcgm
Vitamin C (Ascorbic Acid)	300 mg
Niacinamide	100 mg
Calcium Pantothenate	20 mg

Recommended intake: Adults, 1 capsule daily, for the treatment of vitamin deficiencies. Supplied in decorative "reminder" jars of 30 and 100; bottles of 500.

LEDERLE LABORATORIES, A Division of American Cyanamid Company, Pearl River, New York

691—6—3942

This "case history" runs to some 10,000 pages

This is a typical "case history" of one new drug—or, rather, a proposed new drug—assembled for submission to the U.S. Federal Food and Drug Administration. These volumes are the result of several years' work by thousands of professional and skilled personnel in just one pharmaceutical company's research laboratories, and by hundreds of physicians in medical schools, hospitals, and private practice. They cover every aspect of experience with this proposed new agent from chemical laboratory to clinic, from mouse to man. Each volume could conceivably represent hundreds of thousands of dollars of financial investment, countless hours of human effort. This veritable mountain of data stands behind every new agent offered to you by pharmaceutical manufacturers—a reassuring testimonial to the efficacy, safety and purity of the drugs you will prescribe today to lower the cost of disease to your patients.

Pharmaceutical Manufacturers Association
Pharmaceutical Advertising Council

1155 Fifteenth St., N. W., Washington, D.C. 20005



This message is brought to you as a courtesy of this publication on behalf of the producers of prescription drugs.

Classified Advertisements

Advertising rates for this column are $5.00 per insertion for ads of 25 words or less. Add 20¢ for each additional word.

physicians wanted

General Practitioners

GENERAL PRACTITIONER WANTED (AAGP) for north Florida college town. Vacancy in busy two man practice in medicine, pediatrics and obstetrics. Immediate excellent income with eventual full partnership. Write C-614, P.O. Box 2411, Jacksonville, Fla. 32203.

EXCELLENT OPPORTUNITY for general practitioner in community of 15,000; central Florida; 76 bed JCAH hospital. Write or call collect R. C. Thompson, Bartow Memorial Hospital, Bartow, Fla.

WANTED: General practitioner associate, leading to partnership. Practice approximately one half industrial. Ideal central Florida community. Send detailed resume to C-716, P.O. Box 2411, Jacksonville, Fla. 32203.

GENERAL PRACTITIONER wanted to take over for physician going into residency. Beach community of 10,000; 50 bed hospital. Office and equipment available. Write C-745, P.O. Box 2411, Jacksonville, Fla. 32203.

GENERAL PRACTITIONER needed for independent practice within a three man association. Modern office building in Brooksville, Florida. Contains lab, x-ray and adequate personnel. Advantage of group practice without incumbrances of partnership. Call, write or visit R. A. Henry, M.D., Brooksville, Florida 33512.

WANTED: General practitioner to associate with established young doctor. Also office space available for rent. Contact G. L. Ehringer, M.D., 1184 Oceanshore Blvd., Ormond Beach, Florida 32074.

GENERAL PRACTITIONER WANTED: Partner, semi-rural practice in central Florida area undergoing rapid industrial expansion. Spacious, fully equipped office including x-ray. Good income without working yourself to death. Write C-749, P.O. Box 2411, Jacksonville, Fla. 32203.

WANTED: General practitioner and internist to join group for partnership in Miami area. Must have Florida license and fulfilled military obligation. Write Medical Business Consultants, 9999 N.E. 2nd Ave., Miami Shores, Fla. 33138.

GENERAL PRACTITIONER needed in growing suburban area of 7,000 plus east of Orlando presently without M.D. Area site of new Florida Technological University to be opened 1968. Office space will be built. Contact H. Wayne Todd, D.D.S., 10043 E. Colonial Dr., Orlando 32807, phone (305)277-9420.

WANTED: General Practitioner to work in small hospital in Opa Locka, Florida. Telephone MU 5-2467. A base salary of $20,000 a year will be guaranteed.

WANTED: Young Florida licensed GP or internist to join three man group in West central Florida. Position permanent with future partnership. Write C-764, P.O. Box 2411, Jacksonville, Fla. 32203.

Specialists

PEDIATRICIAN: Board eligible, to join two board pediatricians in rapidly growing Southeastern Florida coastal college town. Early partnership anticipated, excellent hospitals nearby. Send references and curriculum vitae in first letter. C-719, P.O. Box 2411, Jacksonville, Fla. 32203.

OBSTETRICIAN-GYNECOLOGIST WANTED: To associate with two man group. Large established practice in Miami; Board eligible or certified; prefer under age 35. Write P.O. Box 384, Miami Shores, Fla. 33153.

PEDIATRICIAN: To join two pediatricians (shared expenses- individual practices). Must be board qualified, have Florida license, and under age 40. Choice city lower West coast. Write C-729, P.O. Box 2411, Jacksonville, Fla. 32203.

INTERNIST WANTED: Preferably young board qualified or certified internist to associate with well established certified internist in Ft. Lauderdale, Florida. Terms open. Send details first letter. Write C 752, P.O. Box 2411, Jacksonville, Fla. 32203.

PATHOLOGIST: Board eligible or certified, association leading to partnership in active general hospital practice. Write C-763, P.O. Box 2411, Jacksonville, Fla. 32203.

WANTED: Internist to associate with well established internist in Miami, Florida. Terms open. Write Lawson C. Johnson, M.D., 3298 Mary St., Miami, Fla. 33133.

PEDIATRICIAN WANTED: North Dade county. Space available in prestige building. Unusual opportunity for board qualified man. Patient flow in building guarantees instant practice. Inquire Mrs. Brecher, 17301 N.W. 27th Ave., Miami 33054.

real estate

UNUSUAL OPPORTUNITY: Pediatrician, otolaryngologist, general practitioner to locate in beach community. Complete suite in modern building with other physicians. Immediate medical support. Box 605, Melbourne, Fla. 32901.

MEDICAL OFFICE: Ultra-modern building. All services provided. Parking available. Five medical specialists, pharmacy, medical lab now installed. Space for one to three doctors. Write: New England Corporation, 240 New England Building, Winter Park, Fla. 32789. Telephone 644-8217.

AVAILABLE: Otolaryngology office. Immediate occupancy. Ideal location. Excellent opportunity. Capable gross $35,000-$50,000 first year. Owner retiring. Sell or lease. Location excellent for general practice. Write C-746, P.O. Box 2411, Jacksonville, Fla. 32203.

RENTAL PROFESSIONAL SUITES: Modern professional building. Ideal location. Ample parking. 2,250 sq. ft. or any part available. Will design to tenants specifications. 1300 North Federal Highway, Lake Worth, Fla. Phone 582-1760.

OCEAN FRONT HIGH RISE PHYSICIAN'S SUITE. Eight room ocean front physician's suite available August 15. Seventeen story high rise rental apartment building in Daytona Beach (190 units). This suite may be rented furnished or unfurnished. Excellent opportunity. Contact Resident Manager, The Towers Apartments, 2800 North Atlantic Avenue, Daytona Beach, Fla. 32018. Phone 677-8333.

PHYSICIAN WANTED: Redington Beach's Plaza, Gulf Blvd. between 169th and 170th Avenues, N. Redington Beach. We will have available very shortly a 16 x 40 street level store which is now occupied by an osteopath. We are extremely short of doctors in this territory. Reasonable rent. Contact P.O. Box 8065, Madeira Beach, Fla. 33738.

MEDICAL OFFICE SPACE FOR RENT: Have one large space (1,100 sq. ft.) unfinished. Excellent area with large parking space. At present have five physicians and two dentists. Need one more. For information write or call Harry C. Fults, 615 South Missouri, Clearwater, Fla. 33516. Phone 531-4206.

situations wanted

BOARD CERTIFIED ORTHOPAEDIC SURGEON seeking association with another orthopaedic surgeon or multi-specialty group in the southeastern coastal Florida area. Age 40. Florida license. Write P.O. Box 126, Oak Lawn, Illinois 60453.

Miscellaneous

WANTED: Full time resident physicians. Contact Administrator, St. Mary's Hospital, West Palm Beach, Florida for particulars.

WANTED: Assistant medical director for medium size Florida based life insurance company. Prefer physician under 40 with Florida license. Write C-760, P.O. Box 2411, Jacksonville, Fla. 32203.

EXPANDING MULTISPECIALTY CLINIC in Florida needs gastroenterologist, neurosurgeon, orthopedist, otolaryngologist, urologist. Seven man group, state capitol, two universities, 70,000 population. One hour drive to Panama City resort, beautiful rolling hills. Adequate salary first year then partnership. Will equip office. 250 bed hospital 500 ft. away. Resumé to Dr. Gerald N. Bryant, Medical Arts Clinic, Tallahassee, Fla. 32303.

OPPORTUNITY FOR DOCTORS who want to join a multi-specialty group—who want to practice in Florida. A senior surgeon with a large practice and with adequate facilities including laboratory, x-ray and physical therapy departments, desires to confer with board eligible or board certified doctors. The intent is to form a new multi-specialty group practice. Close proximity to a new 500 bed hospital. All inquiries held in strict confidence. Reply to: Jay S. Lombardy & Associates, Management to the Medical Profession, 1177 N.E. 8th St., Delray Beach, Florida 33444.

IMMEDIATE OPENING FOR FLORIDA LICENSED PHYSICIANS for the Emergency Room department. Excellent working conditions; salary open; fringe benefits. Contact Mr. S. A. Mudano, Administrator, Memorial Hospital, Hollywood, Florida 33021.

STUDENT HEALTH PHYSICIANS: Sept. 1967 openings for active young general practitioners, internists or pediatricians interested in adolescent medicine. Comprehensive student health service directed toward modern community health program. Affiliated with major University Medical Center in Southeast. Opportunity for teaching, research and faculty status if qualified. Compensation to $16,500 plus benefits. Enclose full resumé with first correspondence. Write C-762, P.O. Box 2411, Jacksonville, Fla. 32203.

WANTED: Industrial physician for 8000 man plant. Forty hour week; no night calls; two week paid vacation; good insurance program; salary $18,000; position open Sept. 1. Ideal for post coronary or semi-retired physician. Florida licensed required. Write C-765, P. O. Box 2411, Jacksonville, Fla. 32203.

WANTED: An M.D. to be trained to take over entire office in specialty field of hypnosis. Paul S. Symmes, Ph.D., 7630 Biscayne Blvd., Miami, Fla. 33138. Phone 757-4877.

Florida Medical Association

735 Riverside Ave., P. O. Box 2411

Jacksonville, Florida 32203

Officers

W. Dean Steward, M.D., President	Orlando
Jack Q. Cleveland, M.D., President-Elect	Coral Gables
Irving E. Hall Jr., M.D., Vice President	Bradenton
James T. Cook, M.D., Speaker of the House	Marianna
Charles K. Donegan, M.D., Vice Speaker	St. Petersburg
Floyd K. Hurt, M.D., Secretary-Treasurer	Jacksonville
George S. Palmer, M.D., Immediate Past President	Tallahassee
W. Harold Parham, Executive Director	Jacksonville

Councils

Jesse W. Castleberry, M.D., Chairman, Council on Allied Professions and Vocations	Orlando
John J. Cheleden, M.D., Chairman, Judicial Council	Daytona Beach
Jere W. Annis, M.D., Chairman, Council on Legislation and Public Agencies	Lakeland
Jack A. MaCris, M.D., Chairman, Council on Medical Economics	St. Petersburg
James M. Ingram, M.D., Chairman, Council on Medical Services	Tampa
Richard C. Dever, M.D., Chairman, Council on Scientific Activities	Miami
John D. Milton, M.D., Chairman, Council on Special Activities	Coral Gables
Sanford A. Mullen, M.D., Chairman, Council on Specialty Medicine	Jacksonville
Mason Romaine III, M.D., Chairman, Council on Voluntary Health Agencies	Jacksonville

Information for Authors

Manuscripts submitted for publication in the Journal of the Florida Medical Association should be double or triple spaced on white bond, including title page, illustration legends, charts and graphs, table headings, footnotes and bibliography.

Submit original manuscript and two copies. Copying by electrostatic dry process (not wet process) is preferred to tissue copies. Retain one additional copy in your office for proofreading. All material is submitted with the understanding it is subject to editing.

Photographs should be submitted as 5x7 glossy prints, untrimmed and unmounted; number each photograph *lightly* on the back with pencil and indicate top. Charts, graphs and medical illustrations should be submitted as india ink drawings on white gloss paper; remember to make details large enough to allow for photographic reduction. It is a policy of the Journal that authors pay for any cuts made to illustrate their papers.

Titles should be short, specific and clear. Omit phrases such as "The Use of," "Observations on." If paper was presented at a meeting, indicate name of organization, city, month, day and year.

Only original papers not previously published are accepted for publication. Manuscripts submitted for publication are subject to review and approval by the Journal Publications Committee. Except by invitation, only papers from members of the Florida Medical Association are considered for publication.

References should be typewritten, double or triple spaced, beginning on a new sheet of paper entitled "References." Number references in the text in order of citation and prepare bibliography in the same order. Bibliographies should conform to the style of the Index Medicus. The Journal prints only bibliographies of eight references or less; bibliographies of more than eight references are referred to at the end of the paper with the statement "References are available from the author upon request."

All manuscript pages should be numbered consecutively. Within the manuscript, numbers one to nine should be spelled out except when used for units of measurement; for numbers above nine, numerals should be used. Dorland's Medical Dictionary and Webster's International Dictionary may be used as standard references. Scientific names for drugs should be used when possible. Copyright or trade names of drugs should be capitalized.

Index to Advertisers

Abbott Laboratories
Erythrocin Sulfas 752-754

Ames Co., Inc.
Dextrostix 762a

Anderson Surgical Supply Co. 832

Appalachian Hall 829

Ballast Point Manor 833

Bristol Laboratories
Tetrex F. 821

Burroughs-Wellcome Co.
Polysporin 835

Coca-Cola 834

Conal Pharmaceuticals
Urised 834a

Convention Press 832

Duvall Home 826

Gebauer Chemical Co.
Ethyl Chloride 828

Geigy Pharmaceuticals
Tandearil 754-754a

Highland Hospital, Inc. 834

Hill Crest Hospital 832

Hynson, Westcott & Dunning, Inc.
Lutrexin 747

Lakeside Laboratories, Inc.
Inferon 757
Mercuhydrin 762a
Norpramin 824

Lederle Laboratories
Bamadex 758-759
Declomycin 826a
Stresscaps 838a

Eli Lilly & Co.
Co-Pyronil 770
Ilosone 754a
Tuinal 762a
V-Cillin K 818a

Loma Linda Foods
Soyalac 762

Medical Supply Co. 835

National Drug Co.
Quinamm 838a

Parke-Davis & Co.
Benadryl Second Cover

Pitman-Moore Co.
Novahistine LP 831

P. L. Dodge Memorial Hospital 833

PM of Florida 835

William P. Poythress & Co.
Mudrane 769
Solfoton 768

A. H. Robins, Inc.
Robaxin 818a

Roche Laboratories
Valium Back Cover

Wm. H. Rorer, Inc.
Parepectolin 755

Schering Corporation
Drixoral 750a

G. D. Searle Co.
Pro-Banthine 818a

Stamas Boats 750

Stuart Co.
Mylanta 756

Surgical Supply Co. 833

Syntex Laboratories
Synalar 464-467

Tucker Hospital, Inc. 829

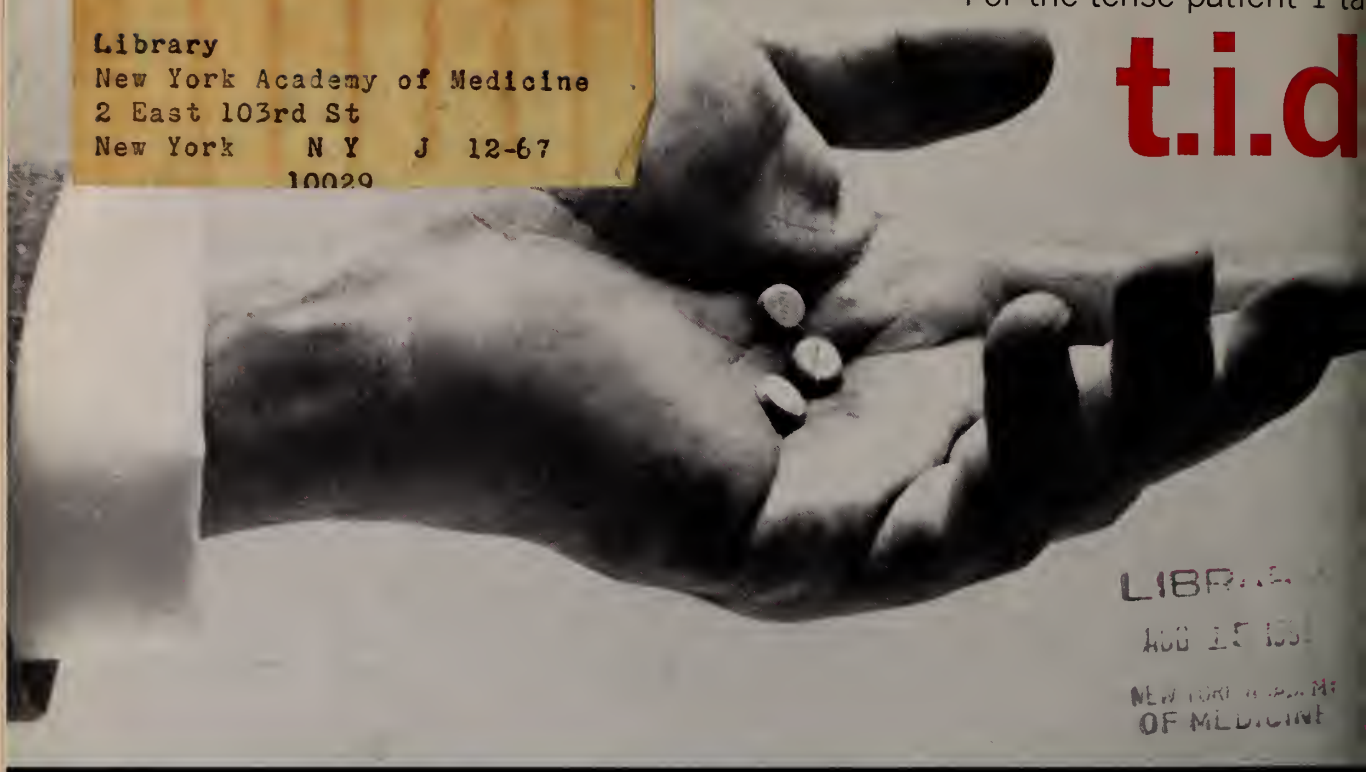
Wyeth Laboratories
Serax 760-761

Wynn Pharmaceuticals, Inc.
Aminophylline Dura-Tabs 748

J 12-67
Library
New York Academy of Medicine
2 East 103rd St
New York N Y J 12-67
10029

For the tense patient 1 ta

t.i.d



LIBRARY
AUG 17 19
NEW YORK ACADEMY
OF MEDICINE

who can't sle

h.s



remember t
extra tablet at bedtim

Valium

(diazepam

Roche®

Before prescribing, please consult complete product information, a summary of which follows:

Contraindications: Infants, patients with history of convulsive disorders or glaucoma.

Warning: Not of value in the treatment of psychotic patients, and should not be employed in lieu of appropriate treatment.

Precautions: Limit dosage to smallest effective amount in elderly patients (not more than 1 mg, one or two times daily) to preclude ataxia or oversedation. Advise patients against possibly hazardous procedures until correct maintenance dosage is established; driving during therapy not recommended. In general, concurrent use with other psychotropic agents is not recommended. Warn patients of possible combined effects with alcohol. Safe use in pregnancy not established. Observe usual precautions in impaired renal or hepatic function and in patients who may be suicidal; periodic blood counts and liver function tests advisable in long-term use. Cease therapy gradually.

Side Effects: Side effects (usually dose-related) are fatigue, drowsiness and ataxia. Also reported: mild nausea, dizziness, blurred vision, diplopia, headache, incontinence, slurred speech, tremor and skin rash; paradoxical reactions (excitement, depression, stimulation, sleep disturbances, hallucinations); changes in EEG patterns. Abrupt cessation after prolonged overdosage may produce withdrawal symptoms similar to those seen with barbiturates, meprobamate and chlordiazepoxide HCl.

Dosage—Adults: Mild to moderate psychoneurotic reactions, 2 to 5 mg b.i.d. or t.i.d.; severe psychoneurotic reactions, 5 to 10 mg t.i.d. or q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; muscle spasm with cerebral palsy or athetosis, 2 to 10 mg t.i.d. or q.i.d. Geriatric patients: 1 or 2 mg/day initially, increase gradually as needed.

Supplied: Tablets, 2 mg, 5 mg and 10 mg; bottles of 50 for convenience and economy in prescribing.

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche
Nutley, N.J. 07110

SEPTEMBER, 1967
Volume 54
Number 9

The JOURNAL of the Florida Medical Association

In This Issue

Ulcerative Colitis
Spastic Esophagus
Multicystic Kidney
Intrauterine Device
Infection Treatment
Pneumocystis Pneumonia

OFFICIAL PUBLICATION OF THE FLORIDA MEDICAL ASSOCIATION

Dilantin®
(diphenylhydantoin)

PARKE-DAVIS

In untold thousands of epileptic patients... Dilantin has been, and continues to be, the bedrock of therapy.

DILANTIN is useful in the treatment of grand mal epilepsy and certain other convulsive states. Its use will prevent or greatly reduce the incidence and severity of convulsive seizures in a substantial percentage of epileptic patients, without the hypnotic and narcotizing effects of many anticonvulsant drugs.
PRECAUTIONS: Periodic examination of the blood is advisable. Nystagmus in combination with diplopia and ataxia indicates dosage should be reduced. The possibility of toxic effects during pregnancy has not been explored. ADVERSE REACTIONS: Allergic phenomena such as polyarthropathy, fever, skin eruptions, and acute generalized morbilliform eruptions with or without fever. Rarely, dermatitis goes on to exfoliation with hepatitis, and further dosage is contraindicated. Gingival hypertrophy, hirsutism, and excessive motor activity are occasionally encountered. During initial treatment, side effects may include gastric distress, nausea, weight loss, nervousness, sleeplessness, feeling of unsteadiness. Macrocytosis, megaloblastic anemia, leukopenia, granulocytopenia, thrombocytopenia, pancytopenia, agranulocytosis, and aplastic anemia have been reported. Nystagmus, lymphadenopathy, lupus erythematosus, erythema multiforme (Stevens-Johnson syndrome), and a syndrome resembling infectious mononucleosis with jaundice have occurred.
DILANTIN is supplied in several forms including Kapseals® containing 0.1 Gm. and 0.03 Gm. diphenylhydantoin sodium.
Parke, Davis & Company, Detroit, Michigan 48232

The color combinations of the banded capsules are Parke-Davis trademarks. The orange-banded white capsule identifies Parke-Davis 0.1 Gm. diphenylhydantoin sodium; the pink-banded white capsule 0.03 Gm. diphenylhydantoin sodium

PARKE-DAVIS 015R67





■ to help restore and stabilize the intestinal flora

■ for fever blisters and canker sores of herpetic origin

LACTINEX contains both *Lactobacillus acidophilus* and *L. bulgaricus* in a standardized viable culture, with the naturally occurring metabolic products produced by these organisms.

First introduced to help restore the flora of the intestinal tract in infants and adults,[1, 2, 3, 4] LACTINEX has also been shown to be useful in the treatment of fever blisters and canker sores of herpetic origin.[5, 6, 7, 8]

No untoward side effects have been reported to date.

Literature on indications and dosage available on request.

References:

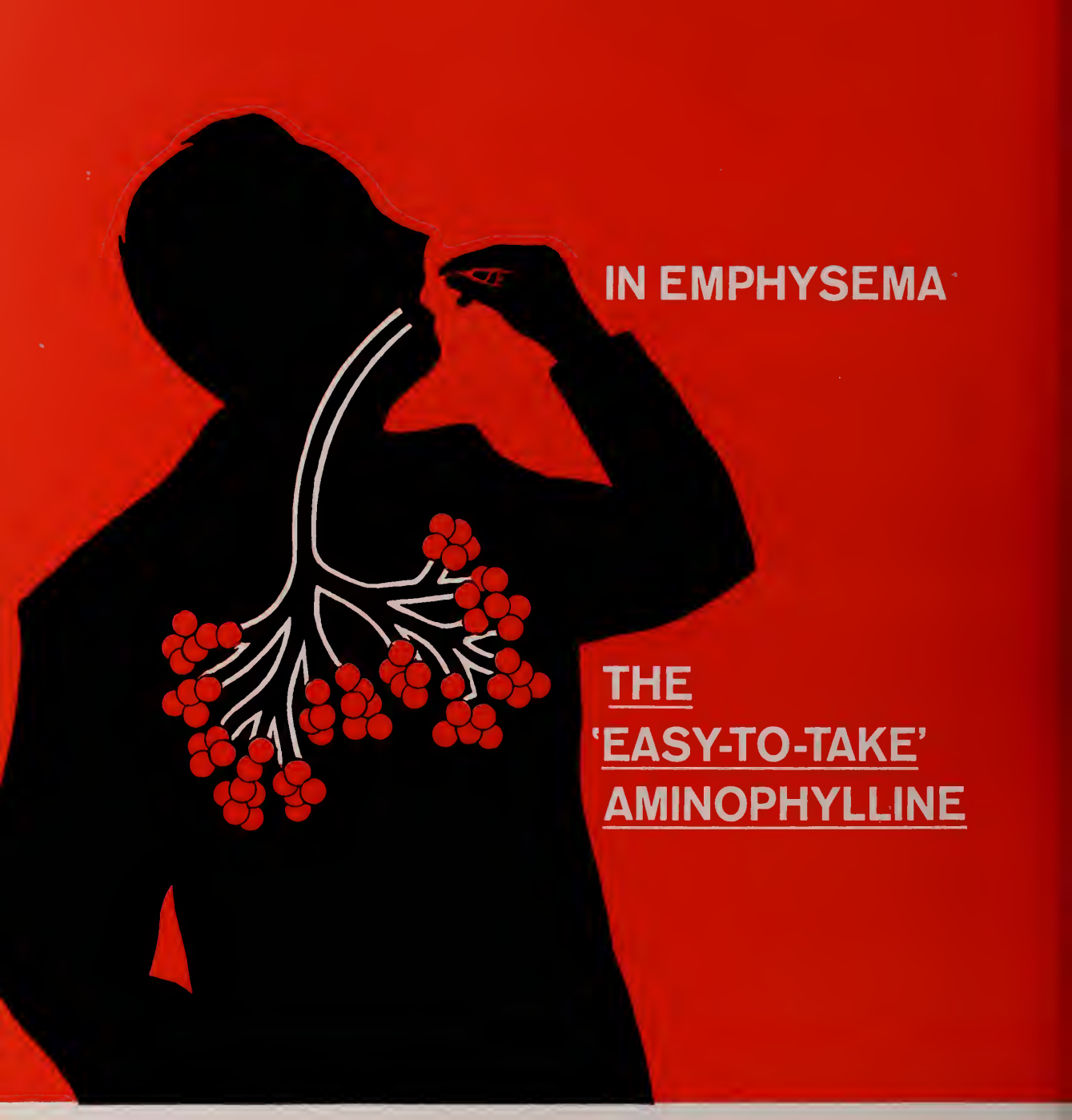
(1) Siver, R. H.: CMD, *21*:109, September 1954. (2) Frykman, H. H.: Minn. Med., *38*:19-27, January 1955. (3) McGivney, J.: Tex. State Jour. Med., *51*:16-18, January 1955. (4) Quehl, T. M.: Jour. of Florida Acad. Gen. Prac., *15*:15-16, October 1965. (5) Weekes, D. J.: N.Y. State Jour. Med., *58*:2672-2673, August 1958. (6) Weekes, D. J.: EENT Digest, *25*:47-59, December 1963. (7) Abbott, P. L.: Jour. Oral Surg., Anes., & Hosp. Dental Serv., 310-312, July 1961. (8) Rapoport, L. and Levine, W. I.: Oral Surg., Oral Med. & Oral Path., *20*:591-593, November 1965.

HYNSON, WESTCOTT & DUNNING, INC.

BALTIMORE, MARYLAND 21201

(LX04)

LX
LX
LX



IN EMPHYSEMA

THE
'EASY-TO-TAKE'
AMINOPHYLLINE

Aminophylline dura-tabs®

prolonged-medication tablets 4½ gr. (0.3 Gm.)

Precautions: Use with caution in patients with poor renal function as a decreased rate of excretion may lead to accumulation and untoward reactions. Gastric irritation may occasionally be observed in certain patients sensitive to oral aminophylline.

Dosage: Adults, 1 to 2 Aminophylline Dura-Tabs each 8 or 12 hours, with food.

RARELY UPSET THE STOMACH

Oral aminophylline needn't disturb the stomach—nor a good night's sleep. Patients breathe easier all day, sleep better all night, as each Aminophylline Dura-Tab dose provides effective therapeutic activity for up to 12 hours. And unlike conventional tablets, AMINOPHYLLINE DURA-TABS seldom cause gastric distress. The special Dura-Tab process allows the gradual absorption of the medication from the intestinal tract with only a small fraction of the dose released in the stomach.

WYNN Pharmaceuticals, Inc. Phila., Pa. 19132 • Manufacturers of QUINAGLUTE® DURA-TABS®
(QUINIDINE GLUCONATE 5 gr.)

A Building Block approach to treating hypertension

With these three therapeutic building blocks you can create a once-a-day regimen to fit almost any degree of hypertension. See the following pages for details . . .



Consider starting your hypertensives on this basic thiazide

ABBOTT

A single daily dose of Enduron provides sodium excretion around the clock

Enduron is a true 24-hour single-dose thiazide. Its sodium excretion is not squeezed into an abrupt peak during the first several hours. It is well-sustained in a plateau-like effect—with little reduction for the first 12 hours, and decline thereafter only gradual.

Potassium loss, by contrast, is low. It reaches an early minor peak, then subsides rapidly. Moreover, since dosage is but once a day, there is but one daily peak of potassium loss. As with all thiazides, however, dietary potassium supplementation should also be considered, especially in long or intensive therapy.

Use Enduron as an ideal starting therapy in mild hypertension. Use it too, as a basic therapeutic building block with which other agents can be joined, for managing your more resistant hypertensives.

Once a day, every day

ENDURON®
METHYCLOTHIAZIDE



DAILY DOSAGE RANGE	Minimum	Usual	Intermediate	Maximum
	2.5 mg. tablet	5 mg. tablet	7.5 mg.	10 mg.

See Brief Summary on final page of advertisement.

To build added response, shift to Enduronyl

The deserpidine component adds enhanced antihypertensive activity

The rauwolfia component of Enduronyl is deserpidine (Harmonyl®), a purified crystalline alkaloid supplied only by Abbott. It augments Enduron with its own antihypertensive and tranquilizing action.

Thus the combined clinical effect of these two therapeutic building blocks in Enduronyl is greater than can ordinarily be achieved with either alone.

To add flexibility, Enduronyl comes in two strengths: regular and Forte. Both provide 5 mg. of Enduron. The variation is where most helpful: in the deserpidine. The tablets are scored, and give a surprisingly wide and economical choice of once-a-day doses (see below).

Choose Enduronyl for your patients in the broad range of mild to moderate hypertension. Patient acceptance is excellent!

Once a day, every day

ENDURONYL®

METHYCLOTHIAZIDE 5 MG. WITH DESERPIDINE 0.25 MG.

ENDURONYL FORTE

METHYCLOTHIAZIDE 5 MG. WITH DESERPIDINE 0.5 MG.



	Minimum	Usual	Intermediate	Maximum
DAILY DOSAGE RANGE	2.5 mg. methyclothiazide 0.125 mg. deserpidine	5 mg. methyclothiazide 0.25 mg. deserpidine	7.5 mg. methyclothiazide 0.375 mg. deserpidine	10 mg. methyclothiazide 0.5 mg. deserpidine
DAILY DOSAGE RANGE	2.5 mg. methyclothiazide 0.25 mg. deserpidine	5 mg. methyclothiazide 0.5 mg. deserpidine	7.5 mg. methyclothiazide 0.75 mg. deserpidine	10 mg. methyclothiazide 1 mg. deserpidine

See Brief Summary on final page of advertisement.

707075-R

Eutonyl affords a different kind of basic therapy for moderate to severe cases

Effect tied to reduced peripheral vascular resistance; no central depressant action

Eutonyl is a unique nonhydrazine agent. It is reported to act by reducing peripheral vascular resistance.[1,2]

In clinical trials, significant reductions in mean blood pressure were seen in 84% of patients studied—all were moderate to severe cases. Eutonyl lowers diastolic in proportion to systolic, and in about half of the cases studied, reductions in the sitting and recumbent positions were nearly as great as in the standing position.

Most important: There is no central depressant action. In fact, some patients reported an *increased* sense of well being.

Here, then, is a highly effective *basic treatment* for moderate to severe cases—and one that will not hamper your patient with lethargy or drowsiness while on treatment.

Once a day, every day

EUTONYL®
PARGYLINE HYDROCHLORIDE



DAILY DOSAGE RANGE	Minimum	Usual starting	Intermediate	Maximum
	10 mg. tablet	25 mg. tablet	50 mg. tablet or as needed	200 mg.

1. Brest, A. N., et al., Cardiac and Renal Hemodynamic Response to Pargyline, Ann. N. Y. Acad. Sci., 107-1016, 1963.
2. Winsor, T., Pargyline Hydrochloride, Hypertension, Urinary Tryptamine, and Vascular Reflexes, Geriatrics, 19:598, Aug., 1964.

See Brief Summary on final page of advertisement.

Eutron adds thiazide for enhanced therapy with milder side effects

ABBOTT

Only a 7/4 mm. span between standing and recumbent pressures in clinical trials—reduced chance of orthostatic hypotension

The combining of Eutonyl and Enduron in Eutron permits a significantly greater antihypertensive effect than with either agent used alone. This in turn may allow therapeutic success with lesser dosage—and correspondingly milder side effects.

A significant finding in clinical trials was the drug's action in lowering blood pressure to *nearly equal levels in all body positions.* Total average spread between standing and recumbent readings (after treatment) was only 7/4 mm. Hg.

Thus, in your moderate to severe cases, Eutron affords a usually smooth course of therapy, often with reduced likelihood of orthostatic effects. (The usual precautions against rising suddenly, of course, will always apply.) And, because of the thiazide component, Eutron may be used in the presence of congestive heart failure.





Once a day, every day

EUTRON™

PARGYLINE HYDROCHLORIDE 25 MG.
WITH METHYCLOTHIAZIDE 5 MG.

	Minimum	Usual starting	Intermediate	Maximum
DAILY DOSAGE RANGE	12.5 mg. pargyline hydrochloride and 2.5 mg. methyclothiazide	25 mg. pargyline hydrochloride and 5 mg. methyclothiazide	37.5 mg. pargyline hydrochloride and 7.5 mg. methyclothiazide	50 mg. pargyline hydrochloride and 10 mg. methyclothiazide

See Brief Summary on final page of advertisement.

TM—Trademark

707075-R

ENDURON® | ENDURONYL®

METHYCLOTHIAZIDE

Each tablet contains
Methyclothiazide 5 mg. with
Deserpidine 0.25 mg. or 0.5 mg.

Indications: Enduron is used to control edema and mild to moderate hypertension; also used with other drugs for hypertension. Enduronyl is used in mild to moderately severe hypertension; when used with Enduronyl, more potent agents can be given at reduced dosage to minimize undesirable side effects.

Contraindications: Neither Enduron nor Enduronyl should be used in severe renal disease (except nephrosis) or shutdown; in severe hepatic disease or impending hepatic coma; in patients sensitive to thiazides. Hepatic coma has been reported as a result of hypokalemia in patients receiving thiazides.

Enduronyl is contraindicated in patients with severe mental depression and suicidal tendencies, active peptic ulcer, or ulcerative colitis.

Warnings: Consider possible sensitivity reactions in patients with a history of allergy or asthma. If added potassium intake is indicated, dietary supplementation is recommended. Enteric-coated potassium tablets should be reserved for cautious use only when adequate dietary supplementation is not practical because those tablets may induce serious or fatal small bowel lesions consisting of stenosis with or without ulceration. These small bowel lesions have caused obstruction, hemorrhage and perforation frequently requiring surgery. Medication should be discontinued immediately if abdominal pain, distension, nausea, vomiting or GI bleeding occurs.

Precautions: Use thiazides with caution in severe renal dysfunction, impaired hepatic function, or progressive liver disease. In surgical patients, thiazides may reduce the response to vasopressors and increase the response to tubocurarine. Use thiazides with caution in pregnancy (bone marrow depression, thrombocytopenia, or altered carbohydrate metabolism have been reported in certain newborn infants). Also reported have been: blood dyscrasias including thrombocytopenia with purpura, agranulocytosis and aplastic anemia; elevations of BUN, serum uric acid, or blood sugar. Symptomatic gout may be induced. Antihypertensive response may be enhanced following sympathectomy.

Use Enduronyl with caution in patients with a history of peptic ulcer, as rauwolfias may increase gastric secretion. Discontinue at the first sign of mental depression. Rauwolfia alkaloids may increase hypotensive effects of surgery or anesthesia, and should be discontinued two weeks prior. They also lower the convulsive threshold and shorten seizure latency. In epilepsy, dosage adjustment of anticonvulsant medication may be necessary. Alcohol, barbiturates, or narcotics may potentiate action of deserpidine.

Adverse Reactions: During intensive or prolonged therapy, guard against hypochloremic alkalosis and hypokalemia (especially the latter if patient is on digitalis). All patients should be observed for signs of hyponatremia ("low-salt" syndrome). Reported thiazide reactions include: anorexia, nausea, vomiting, diarrhea, headache, skin rash, dizziness, paresthesia, weakness, photosensitivity, jaundice, and pancreatitis.

Reported rauwolfia reactions include: nasal stuffiness, nausea, weight gain, diarrhea, aggravation of peptic ulcer, epistaxis, skin eruption, and reduction of libido and potency. Excessive drowsiness, fatigue, weakness, and nightmares may signal early signs of mental depression.

EUTONYL® | EUTRON™

PARGYLINE HYDROCHLORIDE

Each tablet contains
Pargyline Hydrochloride 25 mg.
with Methyclothiazide 5 mg.

Indications: For treatment of patients with moderate to severe hypertension, especially those with severe diastolic hypertension. Not recommended for patients with mild or labile hypertension amenable to therapy with sedatives and/or thiazide diuretics alone. It is desirable to establish the dosage of Eutron by administering component drugs separately.

TM-Trademark.

Contraindications: Pheochromocytoma, advanced renal disease, increasing renal dysfunction, paranoid schizophrenia and hyperthyroidism. Hepatic coma has been reported as consequence of hypokalemia with thiazide therapy. Until further experience is gained not recommended for patients with malignant hypertension, children under 12, or pregnant patients.

Concomitant use of the following is contraindicated: other monoamine oxidase inhibitors; parenteral forms of reserpine or guanethidine; sympathomimetic drugs; foods high in tyramine such as cheese; imipramine and amitriptyline, or similar antidepressants; methyldopa. 2 week interval should separate therapy and use of these agents.

Methyclothiazide is contraindicated in patients with known sensitivity to thiazides.

Warnings: Pargyline hydrochloride is a monoamine oxidase inhibitor. Warn patients against eating cheese, and using alcohol, proprietary drugs or other medication without the knowledge of the physician. When indicated, alcohol, narcotics (meperidine should be avoided), antihistamines, barbiturates, chloral hydrate, and other hypnotics, sedatives, tranquilizers, or caffeine, may be used cautiously in reduced dosage. In emergency surgery ¼ to ⅓ the usual dose of narcotics, analgesics, and other premedications should be used avoiding parenteral administration where possible. Carefully adjust dose of anesthetics to response of patient. Withdraw pargyline two weeks before elective surgery.

Warn patients about the possibility of postural hypotension. Those with angina or coronary artery disease should not increase physical activity with an improvement in well being. Pargyline may lower blood sugar.

Avoid use of enteric-coated potassium tablets, as these may induce serious or fatal small-bowel lesions consisting of stenosis with or without ulceration. These small-bowel lesions have caused obstruction, hemorrhage and perforation frequently requiring surgery. Medication should be discontinued immediately if abdominal pain, distension, nausea, vomiting or GI bleeding occurs. These products contain no added potassium salts and if added potassium intake is desired, dietary supplementation is recommended. Coated potassium tablets should be reserved for cautious use when adequate dietary supplementation is impractical. In patients with a history of allergy or asthma the possibility of sensitivity reactions should be considered.

Precautions: Measure blood pressure while patient is standing to determine antihypertensive effect. Use with caution in hyperactive or hyperexcitable persons. Such persons may show increased restlessness and agitation. Withdraw drug during acute febrile illness. Watch patients with impaired renal function for increasing drug effects or elevation of BUN and other evidence of progressive renal failure; withdraw drug if such alterations persist and progress. Use with caution in patients with liver disease. As with all new drugs, complete blood counts, urinalyses, and liver function tests should be performed periodically. With prolonged therapy, examine patients for change in color perception, visual fields and fundi. Also reported have been: blood dyscrasias including thrombocytopenia with purpura, agranulocytosis and aplastic anemia; elevations of BUN, serum uric acid, or blood sugar. Symptomatic gout may be induced. In surgical patients thiazides may reduce response to vasopressors and increase response to tubocurarine.

Adverse Reactions: Pargyline may be associated with orthostatic hypotension. Mild constipation, slight edema, dry mouth, sweating, increased appetite, arthralgia, nausea and vomiting, headache, insomnia, difficulty in micturition, nightmares, impotence, delayed ejaculation, rash, and purpura have been encountered with pargyline. Hyperexcitability, increased neuromuscular activity (muscle twitching) and other extrapyramidal symptoms have been reported in a few patients with reduced cardiac reserve.

During intensive or prolonged therapy, guard against hypochloremic alkalosis and hypokalemia (especially the latter if patient is on digitalis). Observe all patients for signs of hyponatremia ("low salt" syndrome).

Reported thiazide reactions also include anorexia, nausea, vomiting, diarrhea, headache, dizziness, paresthesia, weakness, skin rash, photosensitivity, jaundice, and pancreatitis. Nocturia has been observed with the combination.



709075R

The JOURNAL
of the Florida Medical Association

Volume 54, Number 9, September 1967

THIS ISSUE

Scientific Articles

Fatal Pneumocystis Pneumonia in an Adult, Giuseppe C. Castellano, M.D. and Eugene H. Ruffolo, M.D ... 869
Collaborative Management of Ulcerative Colitis, Leon Marder, MD. ... 872
Treatment of Serious Infections Due to Common Bacteria, N. Joel Ehrenkranz, M.D., Joseph R. Jannach, M.D. and Peter D. McMichael Jr., M.D. ... 876
The Spastic Esophagus, William L. Baird Jr., M.D. ... 882
Congenital Unilateral Multicystic Kidney, Walter L. Schafer, M.D., Frank V. Fazio, M.D. and Robert E. Sams, M.D. ... 884
Postpartum Insertion of an Intrauterine Device, Peter A. McCranie, M.D. and Doris N. Carson, M.D. ... 887

Special Articles

Future Trends of Psychiatry, E. Arthur Larson, M.D. ... 892
Liberal Abortion Laws: The Antithesis of the Practice of Medicine, Edward J. Lauth Jr., M.D. ... 916
Rx- Professional Liability, Paul Hawkins, CPCU ... 921

Editorial

Don't Confuse Me With the Facts, Collin Baker, M.D. ... 890

Departments

President's Page ... 852
The Medical Detective ... 865
Others Are Saying ... 857
Public Health Topics ... 904
50 Years Ago in the Journal ... 906
Government News ... 908
Classified ... 928

Miscellaneous

Florida Medical Association Officers and Council Chairmen ... 930
Information for Authors ... 930
Index to Advertisers ... 931

THAD MOSELEY, M.D.
Editor

Assistant Editors
JOHN M. PACKARD, M.D.
OSCAR W. FREEMAN, M.D.

Assistant Editor from the Board of Governors
JACK Q. CLEVELAND, M.D.

W. HAROLD PARHAM
Managing Editor

EUGENE L. NIXON
Associate Managing Editor

LOUISE RADER
Assistant Managing Editor

EDITH B. HILL
Editorial Consultant

blished monthly at Jacksonville, rida. Price $7.00 a year: single num-rs, 70 cents. Address Journal of rida Medical Association, P. O. Box 1, 735 Riverside Ave., Jacksonville, h. 32203. Telephone (904) 356-1571. cepted for mailing at special rate of stage provided for in Section 1103, t of Congress of October 3, 1917; thorized October 16, 1918. Entered second class matter under Act of ngress of March 3, 1879, at the post ice at Jacksonville, Florida, October 1924.

Owned and published by the Florida Medical Association, Inc. The Journal is not responsible for the opinions and statements of its contributors.

Don't let monilia cut broad-spectrum therapy short...

start with Tetrex-F®

tetracycline phosphate complex-nystatin

Use of broad-spectrum antibiotics can cause fungal overgrowth in the alimentary tract... and give rise to symptoms so troublesome that therapy must be prematurely stopped. Tetrex-F (tetracycline phosphate complex-nystatin) helps you circumvent this problem.

The nystatin can prevent overgrowth of monilia; the phosphate complex delivers tetracycline to the blood rapidly. Side effects are infrequent.

High-Risk Patients

Tetrex-F (tetracycline phosphate complex-nystatin) is especially useful in patients most susceptible to fungal overgrowth during tetracycline therapy: (1) the elderly or debilitated, (2) young children, (3) the diabetic, (4) those on long-term tetracycline therapy, (5) those on steroid therapy, (6) those who have had moniliasis before, and (7) pregnant patients with a history of monilial vaginitis.

When you start with economical Tetrex-F (tetracycline phosphate complex-nystatin), you can complete the full course of broad-spectrum therapy with less chance of losing control elsewhere. A good start for a healthy finish.

PRESCRIBING INFORMATION. For complete information consult Official Package Circular. *Indications:* Infections of respiratory, gastrointestinal and genitourinary tracts and skin and soft tissues due to tetracycline-sensitive organisms, in patients with increased susceptibility to monilial infections. *Contraindications:* The drug is contraindicated in patients hypersensitive to its components. *Warnings:* Photodynamic reactions have been produced by tetracyclines. Natural and artificial sunlight should be avoided during therapy. Stop treatment if skin discomfort occurs. With renal impairment, systemic accumulation and hepatotoxicity may occur. In this situation, lower doses should be used. Tooth staining and enamel hypoplasia may be induced during tooth development (last trimester of pregnancy, neonatal period and childhood). *Precautions:* Bacterial superinfections may occur. Infants may develop increased intracranial pressure with bulging fontanels. In gonorrheal therapy, serologic tests for syphilis should be conducted initially and monthly for 3 months. *Adverse Reactions:* Glossitis, stomatitis, nausea, diarrhea, flatulence, proctitis, vaginitis, dermatitis, and allergic reactions may occur. *Usual Adult Dosage:* 1 capsule q.i.d. Continue for 10 days in Beta-hemolytic streptococcal infections. Administer one hour before or two hours after meals. *Supplied:* Capsules, bottles of 16 and 100. Each capsule contains tetracycline phosphate complex equivalent to 250 mg. tetracycline HCl activity and 250,000 units of nystatin. For Oral Suspension, 125 mg. tetracycline and 125,000 u. nystatin/5 ml., 60 ml. bottles.

BRISTOL

BRISTOL LABORATORIES
Division of Bristol-Myers Company
Syracuse, New York 13201

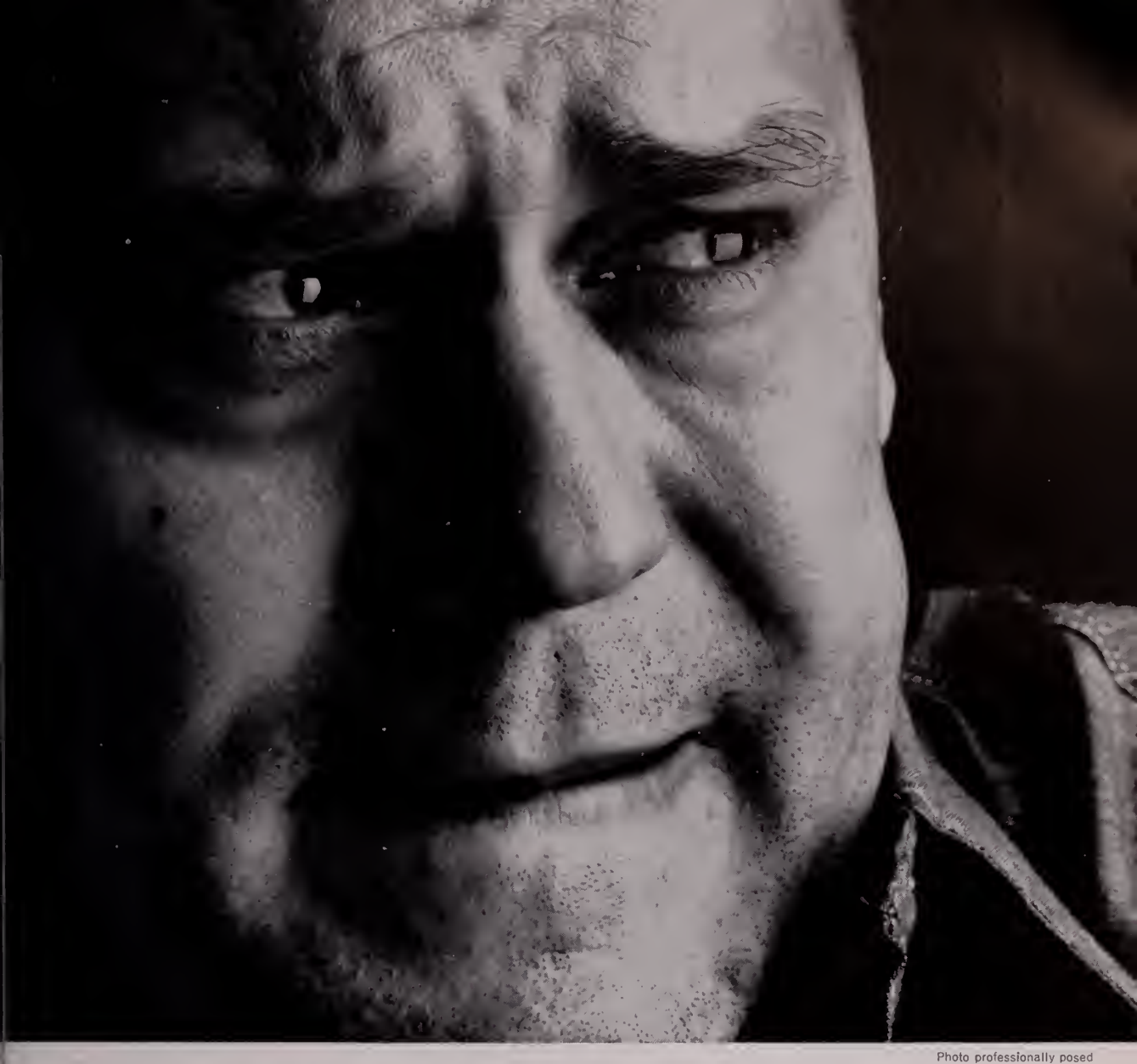


Photo professionally posed

Mike expects a penicillin injection. He's about to be pleasantly surprised.

His physician is going to prescribe an oral penicillin —PEN·VEE® K (potassium phenoxymethyl penicillin). It's usually so rapidly and completely absorbed that therapeutic serum levels are produced in 15 to 30 minutes. Higher serum levels generally last longer than with oral penicillin G.

Indications: Infections susceptible to oral penicillin G: prophylaxis and treatment of streptococcal infections; treatment of pneumococcal, gonococcal, and susceptible staphylococcal infections; prophylaxis of rheumatic fever in patients with a previous history of the disease.

Contraindications: Infections caused by nonsusceptible organisms; history of penicillin sensitivity.

Warnings: Acute anaphylaxis (may prove fatal unless promptly controlled) is rare but more frequent in patients with previous penicillin sensitivity, bronchial asthma or other allergies. Resuscitative (epinephrine, aminophylline, pressor amines) and supportive (antihistamines, methylprednisolone sodium succinate) drugs should be readily available. Other rare hypersensitivity reactions include nephropathy, hemolytic anemia, leucopenia and thrombocytopenia. In suspected hypersensitivity, evaluation of renal and hematopoietic systems is recommended.

Precautions: In suspected staphylococcal infections, perform proper laboratory studies including sensitivity tests. If overgrowth of nonsusceptible organisms occurs (constant observation is essential), discontinue penicillin and take appropriate measures. Whenever allergic reactions occur, withdraw penicillin unless condition being treated is considered life threatening and amenable only to penicillin. Penicillin may delay or prevent appearance of primary syphilitic lesions. Gonorrhea patients suspected of concurrent syphilis should be tested serologically for at least 3 months. When lesions of primary syphilis are suspected, dark-field examination should precede use of penicillin. Treat beta-hemolytic streptococcal infections with full therapeutic dosage for at least 10 days to prevent rheumatic fever or glomerulonephritis. In staphylococcal infections, perform surgery as indicated.

Adverse Reactions (Penicillin has significant index of sensitization): Skin rashes, ranging from maculopapular eruptions to exfoliative dermatitis; urticaria; serum sickness-like reactions, including chills, fever, edema, arthralgia and prostration. Severe and often fatal anaphylaxis has been reported (see "Warnings").

Composition: Tablets—125 mg. (200,000 units), 250 mg. (400,000 units), 500 mg. (800,000 units); Liquid—125 mg. (200,000 units) and 250 mg. (400,000 units) per 5 cc.

ORAL **PEN·VEE® K**

(potassium phenoxymethyl penicillin) Wyeth®



President's Page

The Journal—53 Years of Service

Organized medicine in Florida has every right to be proud of its official publication, the Journal of the Florida Medical Association.

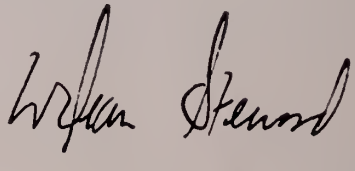
From 1874 through 1913 the proceedings of the annual meetings were published each year. At the 1913 40th Annual Meeting in Miami, a special committee was appointed to study the feasibility of a state journal. At the 41st Annual Meeting in Orlando in 1914 this committee report and recommendation were made a special order of business by the House of Delegates. As a result, the Journal came into being, and its first editor was Dr. Graham E. Henson of Jacksonville. The main object was "to stimulate the interest of the profession in the State in organized medicine in general, and the State Society in particular." At the time there were only 474 members of the society out of 1,177 physicians practicing in Florida. Initially each issue contained about 25 pages, and contained the papers that had been presented at the annual meeting. In 1925 Dr. Shaler Richardson of Jacksonville was elected Editor, and was reelected each year until 1961, with the exception of three years when he served as FMA President Elect (two years) and President. During this period, Dr. Homer Pearson of Miami was Editor. About the time that Dr. Richardson was elected, the House of Delegates put a limit on the number of scientific papers that could be presented at each annual session. As a result there developed a dearth of subject matter, and the Journal suffered accordingly.

In recent years a marked change has occurred due to the acceptance of state medical journals as publishing media. Many articles are submitted each month, and the quality has improved as a result of competition and selection.

In June 1961 Dr. Thad Moseley of Jacksonville was elected Editor Pro Tem and Dr. Richardson was made Editor Emeritus; in February 1962 Dr. Moseley was appointed Editor by the Board of Governors.

In recent years the Journal has changed significantly not only in the quality of material submitted but in the amount and character of advertising carried and in the departmentalization which has occurred, increasing readability. Changes in the past three years have been marked. In 1965, the classified section was departmentalized, Association News reported council and committee meetings for the first time, scientific papers and editorials were cross referenced, a special News department was instituted, a Members in the News department was started, and a listing was carried of National Meetings in Florida which also included all FMA recognized voluntary health agencies. In 1966, the cover appearance was revised, several changes were made in the format of the scientific articles, the President's Page format was changed, and Government News, Special Articles and The Medical Detective departments were started. Other changes were made in type, contents listing and indexing. In 1967, a Public Health Topics department was instituted and the title for the scientific articles section changed to Scientific Section.

The Journal continues to grow in size (now about 100 to 125 pages) and importance. It has become a publication which reflects the increasing prominence of Florida medicine, and those responsible in both editorial and administrative posts deserve our thanks.





fall 1967

DORSEY Season

A journal within a journal published quarterly in the interests of better medicine by Dorsey Laboratories, a division of The Wander Company, Lincoln, Nebraska. Address communications to Raymond C. Pogge, M.D., Director of Medicine.

this issue: smog, smaze or smust...

Smog, smaze or smust...effects of air pollution on upper respiratory tract

Nathan Flaxman, M.D., Diplomate, American Board of Internal Medicine, Chicago, Illinois

In Los Angeles it is *smog* (smoke and fog). In New York City *smaze* (smoke and haze). In El Paso *smust* (smoke and dust). The original factor was smoke plus such natural phenomena as fog, haze and dust, but air pollution has mushroomed from a smoke problem in our industrial cities into a major economic, esthetic and public health problem that affects practically every American locality and citizen.[1,2] Respiratory disease, of course, is by far the most costly effect of air pollution, for contaminated air can aggravate our illnesses, deplete our strength and shorten our life span.[1]

The greatest problem in dealing with solid wastes is that they are not quickly returned to dust. To aid the decomposing process, the great bulk of such waste is burned, polluting our air in the process.[3] Dr. Jack McKee of the California Institute of Technology[4] has calculated that in Los Angeles County, which has more than six million people, about three pounds of gaseous wastes per person per day (on a dry-weight basis) enter the atmosphere. This is twice as much as solid refuse disposal and six times as much as the contaminants in waste water. It is estimated that in New York City, 730 pounds of pollutants, a little over half the size of a compact two-door sedan of foreign make, is annually thrown into the air for each man, woman and child in the city.[5]

Air pollution is an evident factor, not only in the common cold and upper respiratory disease, but also in chronic bronchitis,[2] pulmonary emphysema,[6] bronchial asthma,[7] pneumonitis and lung cancer.[8] Its effect on the incidence of pulmonary tuberculosis is unproved,[9] although it is conceivable that the presence of various materials polluting the air migl do this. A siege of smog in Denver, the "mile hig city," in December 1965 was accompanied by resp ratory infection that doubled normal absentee rat in schools, factories and city government.[10]

While air pollution is only one factor, it has becom important in the causes of most of the afflictions c the respiratory tract. This has been shown not onl by the Denver occurrence, but also by detailed stud of respiratory illness in a small group of 313 me



from October 1962 to May 1963 when there were 202 episodes involving the upper respiratory tract. The attack rate of illness was related in time to increased concentration of both smoke and sulphur dioxide in the atmosphere of the district in which the men lived.

Other factors often mentioned, include exposure to those who have colds, exposure to extreme changes of temperature, allergy and bacterial infection. However, when low individual resistance due to lack of rest, overwork, fatigue, improper or unbalanced diet, previous illness and emotional stress are included as causes, we enter the realm of somewhat obscure relationships. Much more emphasis can be placed on the role of polluted air.

The symptoms, signs and complications of involvement of the upper respiratory tract, especially the common cold, are the same regardless of the causative factor. Swelling of the lining of the nose, the scratchy dry throat, the discharge from the nose at first watery then thicker, discolored and more tenacious, the eyes tearing, and frequent sneezing are all part of the Number 1 human ailment. Concurrent or residual sinusitis when mucus is trapped there, middle ear involvement due to interference with drainage, laryngitis and bronchitis are complications of the common cold. The primary interference is with a most important function of the nose—the cleansing of foreign matter in the first line of "air defense" to prevent it from entering the breathing tract.

However, the diagnosis and subsequent decision on how to treat the patient so affected rests basically on the relief of symptoms that cause him the misery. The stuffed, runny nose, the clogged ears, and the harsh dry cough—all the symptoms that make common cold sufferers feel miserable and interfere with their sleep—can be alleviated with medications of the oral nasal decongestant/antihistamine combination type. The burning sensation in the throat, soreness of the chest and even chest pain can also be relieved by such medication. Rest in bed if there is fever (but confined to home at least), liberal fluids, uniformly warm surroundings and adequate humidity in the room, are all helpful adjuncts to the medication. Most common cold sufferers recover rapidly and are symptom-free in four to ten days.

Further treatment, altered by the fact that the affliction hangs on for more than the usual duration of the common cold, requires consideration of allergy, which is most frequently the prolonging factor. But air pollution itself may often be the culprit.

(Concluded on following page)

For nature's hazards:
nasal congestion
due to seasonal
allergies and
summer colds



Triaminic® *syrup*

Each teaspoonful (5 ml.) contains:

Phenylpropanolamine hydrochloride	12.5 mg.
Pheniramine maleate	6.25 mg.
Pyrilamine maleate	6.25 mg.

For nasal congestion regardless of cause, you can bring quick, lasting comfort to your little patients with Triaminic Syrup. You may occasionally encounter these side effects: drowsiness, blurred vision, cardiac palpitations, flushing, dizziness, nervousness or gastrointestinal upsets. Precautions: the possibility of drowsiness should be considered by patients engaged in mechanical operations requiring alertness. Use with caution in patients with hypertension, heart disease, diabetes, or thyrotoxicosis.

(Advertisement)



At the Third National Conference on Air Pollution held recently, it was emphasized that this subject had received more attention in the past four years than in all previous history. Spicer,[11] an active participant at this conference, reiterated that it behooves the practicing physician to be aware of trends in respiratory disease and to accept a major role in community action relating to air pollution and respiratory health. By taking a positive stand physicians have been instrumental in the development of anti-pollution legislation. An outstanding example is Los Angeles where major steps have been taken by abolishing coal burning, and even banishing oil burning, seven months a year. Natural gas must be used instead and it must be used by industry when available. Backyard incinerators have been abolished in favor of landfill disposal, and building incineration ended except for a few expensive smokeless furnaces.[10] Concerted action can be taken against particular industrial nuisances. One company that disregarded complaints discovered its error when thousands of its credit cards were returned by irate customers who decided to patronize competing companies.[12]

Summary. Respiratory disease is the most important and most costly effect of air pollution, whether termed smog, smaze, or smust. Air pollution is an economic, esthetic and public health problem that affects practically every American locality and citizen. New sources of air pollution are invisible and odorless, but the harmful gases and liquid droplets are there. Triggered by sunlight, some of these undergo mid-air chemical changes and the results are even more irritating to the upper respiratory tract. The symptoms, signs and complications, especially of the upper respiratory tract, can be readily aborted by modern medication but may be unduly prolonged by polluted air. In steps taken to prevent this, the practicing physician can take a major role.

References 1. Anderson, R. J. Air Pollution, Respiratory Disease and the NTA, W. Virg. M. J., 60:332, 1964. 2. Angel, J. H., Fletcher, C. M., Hill, I. D., and Tinker, C. M. Respiratory Illness in Factory and Office Workers, Brit. J. Dis. Chest, 59:66, 1965. 3. Waste Disposal Problems Grow, Current Municipal Problems, 8:218, 1966. 4. McKee, J. quoted by Hills, G. U.S. War at Home-Fight Against Smog, Chicago Tribune, Sept. 26, 1966. 5. NYC Task Force Revives Concern on Air Pollution, Med. Trib. 7:23 (Sept. 17-18) 1966. 6. Flaxman, N. Pulmonary Emphysema, Med. Trial Tech. Quart. 1960 Annual, p. 221. 7. Heimann, H. Air Pollution and Respiratory Disease, Ann. Allergy 21:396, 1963. 8. Flaxman, N. Pneumonitis and Lung Cancer, Med. Trial Tech. Quart. 1965 Annual, p. 185. 9. Flaxman, N. Pulmonary Tuberculosis, Occupation and Trauma, Med. Trial Tech. Quart. 1959 Annual, p. 237. 10. Hill, G. U.S. War at Home-Fight Against Smog, Chicago Tribune, Sept. 26, 1966. 11. Spicer, W. S., Jr. Relation of Air Pollution to Disease, Arch. Environ. Health, 9:600, 1964. 12. Henderson, C. F. What You Can Do To Combat Air Pollution, Parents' Mag. 41:76, 1966.

How can he be a sport with a runny nose?



For summer allergies, summer colds, or nasal congestion due to almost any cause, you prescribe quick r-e-l-i-e-f with Triaminic. It's ideal for summer allergies:

1. Acts in 15-30 minutes due to decongestant.
2. Follows up with balanced dual antihistamines.
3. Up to 24-hour 'round the clock relief when dosed one tablet at morning, midafternoon and evening.

Summer time is sport time and who can be a sport with a runny nose?

provide patient comfort

Triaminic® relieves summer allergies

Each timed-release tablet contains:

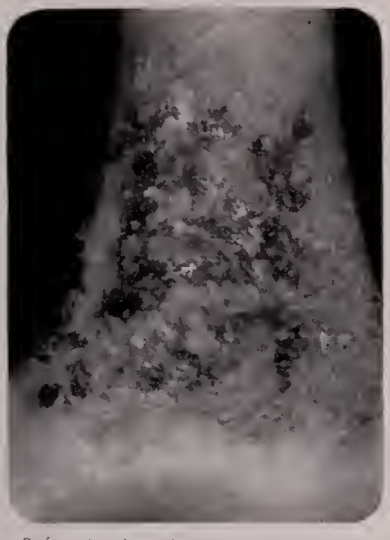
Phenylpropanolamine hydrochloride	50 mg.
Pheniramine maleate	25 mg.
Pyrilamine maleate	25 mg.

Side effects: Occasional drowsiness, blurred vision, cardiac palpitation, flushing, dizziness, nervousness or gastrointestinal upsets.

Precautions: The patient should be advised not to drive a car or operate dangerous machinery if drowsiness occurs. Use with caution in patients with hypertension, heart disease, diabetes or thyrotoxicosis.

(Advertisement)

Eczema of many years... controlled in two weeks



Before treatment



After treatment —
with ARISTOCORT Topical Ointment 0.1% for two weeks

ARISTOCORT® Triamcinolone Acetonide Topicals have proved exceptionally effective in the control of various forms of eczema: allergic, atopic, nummular, psoriatic, and mycotic.

In most cases responsive to topical ARISTOCORT, the 0.1% concentration is sufficiently potent. The 0.5% concentration provides enhanced topical activity for patients requiring additional potency for proper relief.

Administration and Dosage: Apply sparingly to the affected area 3 or 4 times daily. Some cases of psoriasis may be more effectively treated if the 0.1% Cream or Ointment is applied under an occlusive dressing.

Contraindications: Tuberculosis of the skin, herpes simplex, chicken pox and vaccinia.

Precautions and Side Effects: Do not use in the eyes or in the ear (if drum is perforated). A few individuals react unfavorably under certain conditions. If side effects are encountered, the drug should be discontinued and appropriate measures taken. Use on infected areas should be attended with caution and observation, bearing in mind the potential spreading of infection and the advisability of discontinuing therapy and/or initiating antibacterial measures. Generalized dermatological conditions may require systemic corticosteroid therapy. Steroid therapy, although responsible for remissions of dermatoses, especially of allergic origin cannot be expected to prevent recurrence. The use over extensive body areas, with or without occlusive nonpermeable dressings, may result in systemic absorption. Appropriate precautions should be taken. When occlusive nonpermeable dressings are used, miliaria, folliculitis and pyodermas will sometimes develop. Localized atrophy and striae have been reported with the use of steroids by the occlusive technique. When occlusive nonpermeable dressings are used, the physician should be aware of the hazards of suffocation and flammability. The safety of use on pregnant patients has not been firmly established. Thus, do not use in large amounts or for long periods of time on pregnant patients.

Available in 5 Gm. and 15 Gm. tubes and ½ lb. jars.

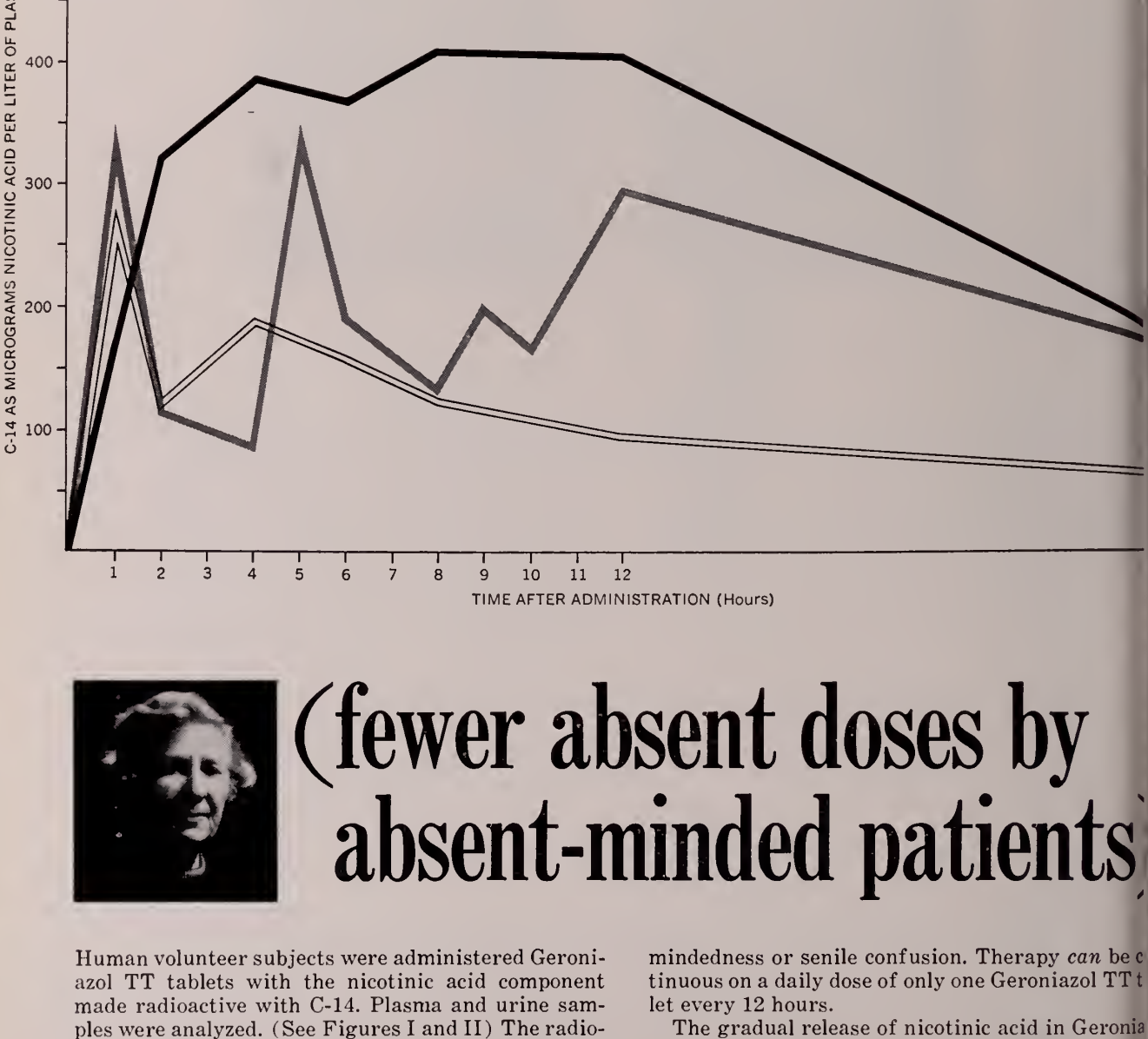
PHOTOGRAPHS COURTESY OF M. M. NIERMAN, M.D.

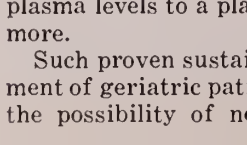
Aristocort® Topical Ointment 0.1% and Cream 0.1%, 0.5%
Triamcinolone Acetonide
Also available in foam form.

Lederle LEDERLE LABORATORIES, A Division of American Cyanamid Company, Pearl River, New York

406-6

Sustained circulatory, respirato and cerebral stimulation for t





(fewer absent doses by absent-minded patients)

Human volunteer subjects were administered Geroniazol TT tablets with the nicotinic acid component made radioactive with C-14. Plasma and urine samples were analyzed. (See Figures I and II) The radioactive tracer study substantiated the previous clinical evidence that the release of nicotinic acid from the Geroniazol TT tablet produced a gradual rise in plasma levels to a plateau for a total of 12 hours and more.

Such proven sustained activity makes the management of geriatric patients much easier by minimizing the possibility of neglected doses through absent-mindedness or senile confusion. Therapy *can* be c tinuous on a daily dose of only one Geroniazol TT t let every 12 hours.

The gradual release of nicotinic acid in Geronia TT will provide the well-known peripheral vasodila tion needed in patients with deficient circulation a with a minimum amount (if any) of "flushing." A cerebrovascular circulation is complemented by p tylenetetrazol, long-established as a cerebral and r piratory stimulant.

Geroniazol TT improves the typical, unfortuna signs of senile confusion. Patients become more al

ed and debilitated

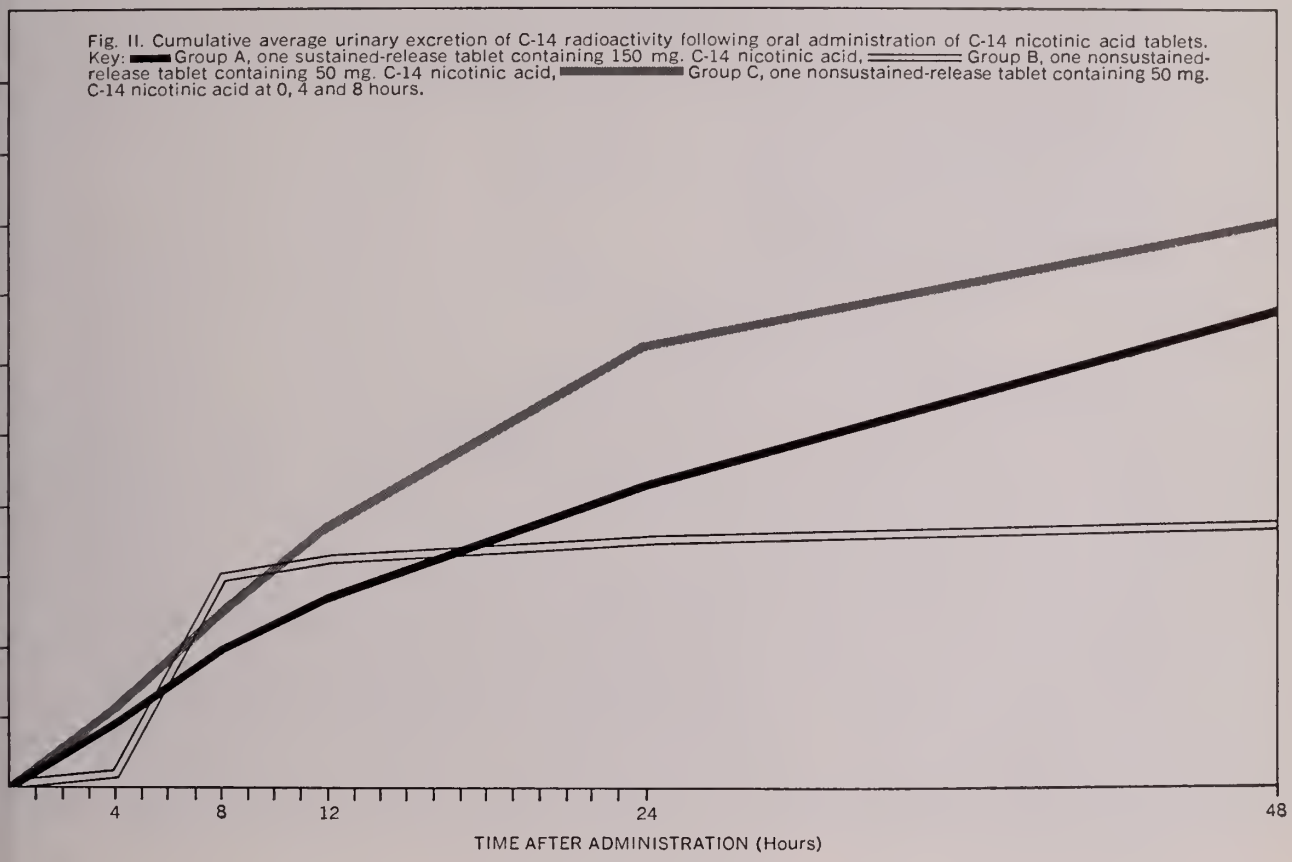


Fig. II. Cumulative average urinary excretion of C-14 radioactivity following oral administration of C-14 nicotinic acid tablets. Key: ▬ Group A, one sustained-release tablet containing 150 mg. C-14 nicotinic acid, ═══ Group B, one nonsustained-release tablet containing 50 mg. C-14 nicotinic acid, ▬▬▬ Group C, one nonsustained-release tablet containing 50 mg. C-14 nicotinic acid at 0, 4 and 8 hours.

confused and moody. Personal care, memory, tional stability, social attention improve. Fatigue, hy and irritability are reduced.

prescription for 100 tablets of Geroniazol TT will nit your patients to enjoy the benefits of time-nged nicotinic acid/pentylenetetrazol therapy, economical price. Dosage is only one tablet every urs.

raindications: There are no known contraindica-

autions: Exercise caution when treating patients a low convulsive threshold.

Side Effects: Side effects are rarely encountered, however due to the vasodilatation effect of nicotinic acid, transitory mild nausea, flushing, tingling and pruritus are possible.

Dosage: One tablet every 12 hours.

Supplied: Prescribe bottles of 100 tablets, to take advantage of recent price reduction.

References: 1. Report by Nuclear Science & Engineering Corp., Pittsburgh, Pa., in files of Philips Roxane Laboratories. 2. Connolly, R.: W. Virginia Med. J. *56*:263 (Aug.) 1960. 3. Curran, T. R., and Phelps, D. K.: Am. Pract. & Digest Treat. *11*:617 (July) 1960.

"First with the Retro-Steroids"
PHILIPS ROXANE LABORATORIES
Division of Philips Roxane, Inc., Columbus, Ohio
A Subsidiary of Philips Electronics and Pharmaceutical Industries Corp.

Geroniazol® TT

nicotinic acid 150 mg., pentylenetetrazol 300 mg.
Tempotrol® Time Controlled Tablet

In peptic ulcer... antacid therapy with a new benefit



CONTAINS A BALANCED COMBINATION OF THE MOST WIDELY USED ANTACIDS— FOR RAPID NEUTRALIZATION. PLUS SIMETHICONE— TO CONTROL THE FACTOR WHICH ANTACIDS ALONE CANNOT INFLUENCE.

Mylanta®

- In Mylanta, aluminum and magnesium hydroxides are balanced to minimize the chance of constipation or laxation and still achieve rapid acid neutralization and pain relief.
- The positive action of simethicone helps relieve the painful gas symptoms which often accompany the peptic ulcer syndrome.
- The nonfatiguing flavor and smooth, nongritty consistency of tablets and liquid encourage continued patient cooperation during long-term therapy.

Composition: Each Mylanta chewable tablet or teaspoonful (5 ml.) of liquid contains: magnesium hydroxide, 200 mg.; aluminum hydroxide, dried gel, 200 mg.; simethicone, 20 mg. **Dosage:** one or two tablets, well chewed or allowed to dissolve in the mouth, or one or two teaspoonfuls of liquid to be taken between meals and at bedtime.

The Stuart Company, Pasadena, California
Division of Atlas Chemical Industries, Inc.

Stuart

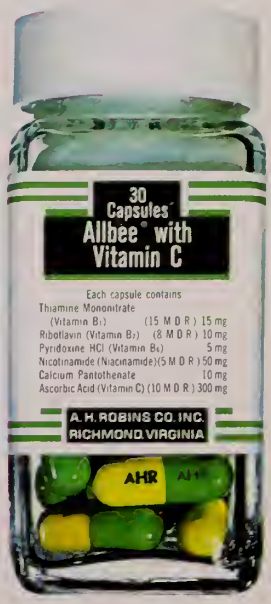
Two ways to give your patients a month's therapeutic supply of vitamin C:



118 grapefruit or 30 Allbee® with C

Your patient would have to eat 118 medium-sized grapefruit (almost 4 a day!) to get as much vitamin C as is provided in just one bottle of 30 Allbee with C capsules (taken one capsule daily). In addition, each capsule supplies full therapeutic amounts of the B-complex vitamins.

Your patients can purchase Allbee with C capsules in the convenient bottle of thirty—a month's supply at a very reasonable price. Also the economy size of 100. Available at pharmacies everywhere on your prescription or recommendation.



A-H-ROBINS

A. H. Robins Company, Richmond, Virginia



the spasm
reactors
n your practice
deserve

"the Donnatal Effect"

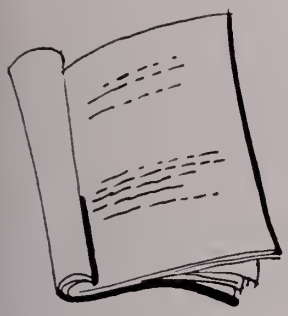
	each tablet, capsule or 5 cc of elixir (23% alcohol)	each Extentab
hyoscyamine sulfate	0.1037 mg.	0.3111 mg.
atropine sulfate	0.0194 mg.	0.0582 mg.
hysocine hydrobromide	0.0065 mg.	0.0195 mg.
phenobarbital	(¼ gr.) 16.2 mg.	(¾ gr.) 48.6 mg.

(Warning: may be habit forming)

A. H. ROBINS COMPANY, RICHMOND, VIRGINIA 23220

Brief summary. Blurring of vision, dry mouth, diffi urination, and flushing or dryness of the skin occur on higher dosage levels, rarely on usual d Administer with caution to patients with incipi glaucoma or urinary bladder neck obstruction. Cont indicated in acute glaucoma, advanced renal or hep disease or a hypersensitivity to any of the ingredi

A·H·ROBINS



Others Are Saying

Medicare Reimbursement Program

V. D. Mattia, M.D.
President, Roche Laboratories
Division of Hoffman-La Roche, Inc.
Nutley, New Jersey 07110
Dear Dr. Mattia:

The Board of Directors of The Arizona Medical Association, Inc., has directed me to communicate with you expressing appreciation on behalf of the physicians of this State for the Roche program for supplying drugs to indigent patients. This is indeed a warm, human and truly charitable undertaking.

Secondly, I am directed to express our disapproval of the Roche program to reimburse hospitals a percentage of drug costs expended for Medicare patients. The following may explain our attitude in this regard:

1. The medical profession opposed Medicare on the grounds that it did not limit assistance to those in need. Indeed, our wealthiest patients are among the Medicare group. It would be ludicrous to postulate that such a refund is needed by a fair percentage of those over 65 years of age.
2. The Congress, in enacting the Medicare law, stated that its purpose was to eliminate the "second-class citizen" or those who depended upon charity, rebates or handouts, thus protecting their dignity and personal image.
3. If it is proper, necessary or indicated for Roche to rebate any sum to any agency or institution for the cost of any part of Medicare, then, by the same token, it is fitting and proper for medicine and others to rebate a portion of their fees.
4. Inasmuch as hospitals are reimbursed by the government on a cost basis, we fail to see how this benefits the hospital, and, indeed, the record-keeping might be more costly than the amount rebated.
5. Roche's gesture, no matter how well intentioned, puts other drug firms, physicians and hospital suppliers in a position of unbalance when future negotiations regarding supplier costs are considered.
6. It would appear that Roche is paying its *full* share of taxes; Roche's employees are subject to the *full* amount of withholding; and Roche's investors are entitled to a *full* return on their investment.

The physicians of Arizona believe this gesture on the part of Roche is ill-advised, poorly conceived, accomplishes little, and tends to establish a precedent that reflects unfavorably on the concept of "usual and customary" payments that the profession has fought so hard to establish and maintain.

Sincerely,
Paul B. Jarrett, M.D., President
The Arizona Medical Association, Inc.

Paul B. Jarrett, M.D., President
The Arizona Medical Association, Inc.
Suite 201
4601 North Scottsdale Road
Scottsdale, Arizona 85251

Dear Doctor Jarrett:

Thank you for writing to me about the Roche Medicare Reimbursement Program. While I am grateful for your comments, I would like to state our position regarding some of the points raised in your letter.

It is a fact that Medicare has become the law of the land; how will it affect the future of medical practice? No matter what our personal opinion of this legislation may be, it is going to be with us and, therefore, we have to ponder its implications for the future.

It is reasonable to assume that the people of this country and their representatives in Congress will observe carefully how Medicare works. If its cost is kept within reasonable limits, the chances are excellent that there will be no further legislation along these lines. In other words, we shall continue to enjoy free choice of physicians in private practice, linked to the time-tested American system of direct, intimate physician-patient relationship.

But if the cost of Medicare should rise steeply, there is a definite risk that additional legislation, drafted by men interested in greater government control of medicine, will be enacted. In attempting to reduce the cost of medical care, such new laws might well result in greater interference with the private practice of medicine as we have known it.

Therefore, I believe that ethical pharmaceutical companies should do whatever they can to keep the cost of drugs used by Medicare within reasonable bounds. Once the American public becomes aware of our sincere efforts to keep the cost of Medicare at a fair and equitable level, the people of this country and their elected representatives will be much more likely to resist future proposals for government interference with the practice of medicine.

We consider it our responsibility to assist all members of the medical profession by providing the highest quality medical care for all patients regardless of their economic circumstances. Consequently, as I mentioned in my letter of August 8, we instituted the Roche Indigent Patient Program where physicians in private practice can obtain at any time any Roche products for their needy patients without charge. This program, therefore, benefits one segment of our society.

Since we believe ethical pharmaceutical companies should do whatever they can to keep the cost of drugs used by Medicare within reasonable bounds, we introduced the Roche Medicare Reimbursement Plan, designed to reduce the problem of spiraling costs in hospitals. However, we definitely have no intention or desire to overcharge other-than-Medicare patients, since there will be no change in the prices of our drugs.

The Roche program, therefore, is a sincere attempt to move forward with a *voluntary* program in the interest of the nation, the industry, and our company.

I am sorry that you feel as you do about our Medicare Reimbursement Plan, but occasionally we must make decisions which will not be received enthusiastically by all segments of the community. We shall nevertheless continue our endeavors to fulfill a pressing need in a manner we believe to be in the best interest of all concerned. I feel certain that basically this is what you and your members would wish also.

Sincerely,
V. D. Mattia, M.D.
President
Roche Laboratories

GOOD HEALTH TO ALL

Hopefully, we can look forward to a year of good health in 1967.

As the American Medical Association points out, the past year was one of encouraging developments that may help ensure many of us a longer, more comfortable life.

Here's some of the medical progress of 1966:

—The first successful implantation of artificial devices, popularly but incorrectly called "artificial hearts," into the chests of human beings to aid

failing hearts.

—A drug that preliminary investigation indicated may improve memory.

—A dignified scientific study that gives clearer understanding of the mysteries of human sexual response.

—Adaptation and improvement of Russian-built artificial limbs by Canadian physicians. These devices derive motive power from the electric potential of muscle, eliminating the need for straps and springs.

The past year saw many American physicians volunteer their skills to help fill the immense need of the South Vietnamese people for medical care. The program through which they volunteer for 60 days of service in Vietnamese hospitals is known as AMA Volunteer Physicians for Viet Nam.

This past year was one in which American medicine made solid proposals for the kind of medical education required to provide communities with family physicians—a new kind of physician, broadly educated in continuous, comprehensive health care.

Finally, 1966 might be characterized as the year of vaccines. A mumps vaccine proved nearly 100 per cent effective in clinical trials. A prophylactic vaccine showed nearly total effectiveness in protecting unborn infants against the deadly "Rh factor" in some mothers' blood. Work continued on German measles vaccines, with great success reported in human trials. Wide use of existing vaccines was urged in a campaign to stamp out measles.

We are not yet at the end of the road to perfect health. Medicine makes no promise that we will ever get there—certainly not in the near future. Physicians still lose battles against such old killers as heart disease, stroke, and cancer.

But our prospects continue to improve for a rich, full life and a meaningful old age. One of the people we can thank for this is the American doctor.

Reprinted from Dunedin Times, Jan. 5, 1967.

A Venerable Institution

One of the most venerable institutions in America is the American Medical Association. The AMA is the principal spokesman for the medical profession in the United States. Its wide-ranging activities in scientific and medical matters have made it, perhaps, the most important association of its kind in the world today. In the words of one of its top officials, "The American Medical Association, since its founding 118 years ago, has matured into a dynamic and vital force in the affairs of this nation. Its numerous and varied programs affect the lives of all citizens of this country and millions of other people around the world."

Many people think of the AMA as primarily a voice for the medical profession on important medical issues, such as Medicare. It does, in fact, speak out on issues where it feels it must do so in the best interests of high medical standards and the health of the people. But, its role in controversial public issues is minor compared to its main task of helping the profession it represents and the American public adjust to an explosion of medical and scientific knowledge, unprecedented in the history of mankind. For example, the Department of Mental Health of the AMA has been responsible, not only for distribution of information, but development of key concepts affecting the health of millions of persons. Another department is concerned with foods and nutrition. And still another is responsible for collecting, evaluating and disseminating information on drugs and cosmetics. In 1965, it made available to the association members, 108 scientific publications dealing with these subjects.

Another important activity of the AMA, involves the periodic accreditation surveys of the American Medical Association, in a very large part, must be given credit for the present stature of the medical arts and sciences in this country.

Reprinted from the Greater Miami Journal, Jan. 5, 1967.

IRON DEFICIENCY

ANEMIA



Imferon®
(iron dextran injection)

There's as much iron . . . 250 mg. . . . in a 5 cc. ampul of Imferon (iron dextran injection) as in a pint of whole blood. When iron deficient patients are intolerant of oral iron . . . or orally administered iron proves ineffective or impractical . . . or if the patient cannot be relied upon to take oral iron as prescribed, Imferon (iron dextran injection) dependably increases hemoglobin and rapidly replenishes iron reserves. Precise dosage is easily calculated.

LAKESIDE

IN BRIEF: ACTION AND USES: A single dose of Imferon (iron dextran injection) will measurably begin to raise hemoglobin and a complete course of therapy will effectively rebuild iron reserves. The drug is indicated only for specifically-diagnosed cases of iron deficiency anemia and then only when oral administration of iron is ineffective or impractical. Such iron deficiency may include: patients in the last trimester of pregnancy; patients with gastrointestinal disease or those recovering from gastrointestinal surgery; patients with chronic bleeding with continual and extensive iron losses not rapidly replenishable with oral iron; patients intolerant of blood transfusion as a source of iron; infants with hypochromic anemia; patients who cannot be relied upon to take oral iron.

COMPOSITION: Imferon (iron dextran injection) is a well-tolerated solution of iron dextran complex providing an equivalent of 50 mg. in each cc. The solution contains 0.9% sodium chloride and has a pH of 5.2-6.0. The 10 cc. vial contains 0.5% phenol as a preservative.

ADMINISTRATION AND DOSAGE: Dosage, based upon body weight and Gm. Hb/100 cc. of blood, ranges from 0.5 cc. in infants to 5.0 cc. in adults, daily, every other day, or weekly. Initial test doses are advisable. The total iron requirement for the individual patient is readily obtainable from the dosage chart in the package insert. Deep intramuscular injection in the upper outer quadrant of the buttock, using a Z-track technique, (with displacement of the skin laterally prior to injection), insures absorption and will help avoid staining of the skin. A 2-inch needle is recommended for the adult of average size.

SIDE EFFECTS: Local and systemic side effects are few. Staining of the skin may occur. Excessive dosage, beyond the calculated need, may cause hemosiderosis. Although allergic or anaphylactoid reactions are not common, occasional severe reactions have been observed, including three fatal reactions which may have been due to Imferon (iron dextran injection). Urticaria, arthralgia, lymphadenopathy, nausea, headache and fever have occasionally been reported.

PRECAUTIONS: If sensitivity to test doses is manifested, the drug should not be given. Imferon (iron dextran injection) must be administered by deep intramuscular injection only. Inject only in the upper outer quadrant of the buttock, not in the arm or other exposed area.

CONTRAINDICATIONS: Imferon (iron dextran injection) is contraindicated in patients sensitive to iron dextran complex. Since its use is intended for the treatment of iron deficiency anemia only it is contraindicated in other anemias.

CARCINOGENICITY POTENTIAL: Using relatively massive doses, Imferon (iron dextran injection) has been shown to produce sarcoma in rats, mice and rabbits and possibly in hamsters, but not in guinea pigs. The risk of carcinogenesis, if any in man, following recommended therapy with Imferon (iron dextran injection) appears to be extremely small.

SUPPLIED: 2 cc. ampuls, boxes of 10; 5 cc. ampuls, boxes of 4, 10 cc. multiple dose vials.

LAKESIDE LABORATORIES, INC., Milwaukee, Wisconsin 53201



New view of an oral contraceptive at work

Although suppression of ovulation remains the primary mode of action of oral contraceptives, newer knowledge indicates that products like Norinyl-1—a combination of both low-dosage progestogen and estrogen for the full treatment cycle—may provide multiple action that helps explain their unexcelled record of contraceptive effectiveness. This report explores the possible secondary protective mechanisms offered by combined hormonal administration.

Accumulating evidence has indicated that sparse, highly viscous cervical mucus has a possible adverse effect on the motility and survival of spermatozoa.

The estrogen-opposing progestational ingredient of Norinyl-1 (norethindrone 1 mg. with mestranol 0.05 mg.) changes the usual midcycle picture of a thin, watery cervical mucus. The result—a built-in barrier that appears to inhibit sperm from reaching the ovum should one be released. The inset in the adjoining photograph shows immobile spermatozoa as they appear in cervical mucus taken from a patient treated with Norinyl-1.

See last page for contraindications, precautions, side effects and dosage.

How the estrogen-opposing action of Norinyl-1 creates cervical mucus that may be hostile to sperm penetration

Normally, estrogen activity during the fertile midcycle stimulates the production of a profuse and watery cervical mucus that permits maximum sperm motility and promotes penetration.

But what happens when Norinyl-1 is administered? Its potent progestogen, norethindrone, opposes estrogen stimulation of cervical mucus. Consequently, the amount of mucus decreases and its viscosity increases. This results in a sparse but thick mucus barrier that appears to diminish the vitality of the sperm and to impair its powers of penetration.

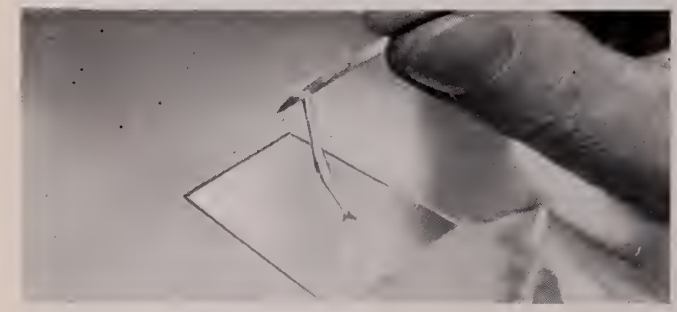
The role of viscous cervical mucus as a secondary action of Norinyl-1

In a report on 89 patients taking this medication,* cervical mucus obtained from cycle day 5 to cycle day 29 appeared scant and thick and exhibited little or no Spinnbarkeit.

In the opinion of this investigator, the effect on cervical mucus may be sufficient to prevent conception.

*Cohen, M. R.: Symposium: Mechanisms of Action of Low Dosage Oral Contraceptive, Yale University Medical Center, New Haven, Conn., April 6, 1967.

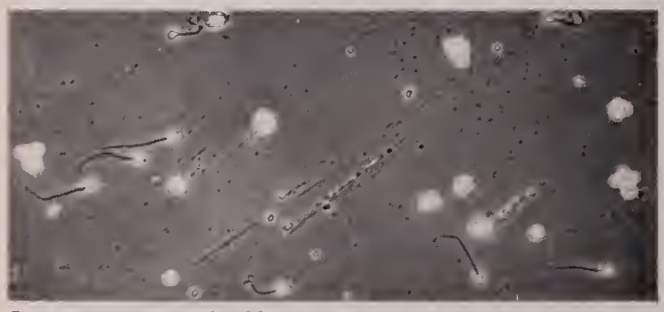
Normal cervical mucus at midcycle in untreated patient is known to permit sperm motility... promote sperm penetration.



Cervical mucus is thin and watery with a stretchability (Spinnbarkeit) of 15 to 20 cm.



Thin, watery mucus crystallizes into this well-defined, fernlike pattern within a minute.

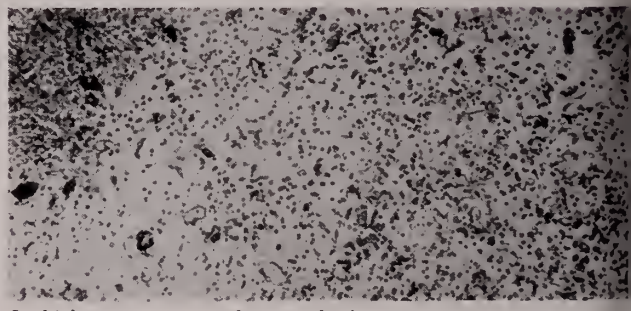


Spermatozoa appear healthy, are active and freemoving.

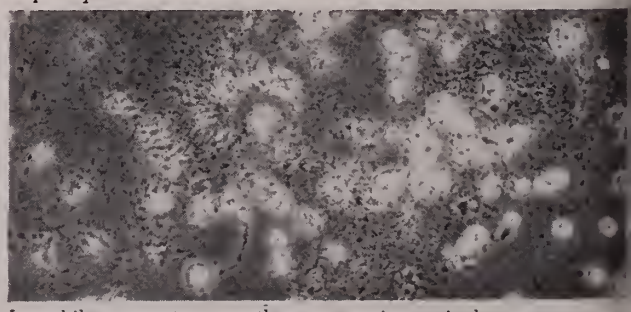
Viscous cervical mucus at midcycle produced by Norinyl-1 appears to impair sperm vitality... inhibit penetration.



Cervical mucus is scanty, thick and viscous. Spinnbarkeit is 1 cm. or less.



In thick, viscous cervical mucus the fern pattern is poorly defined or absent.

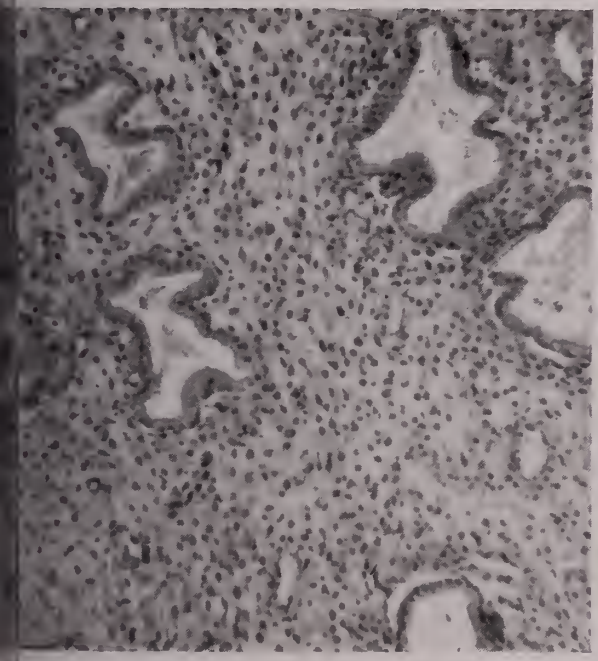


Immobile spermatozoa as they appear in cervical mucus taken from a patient treated with Norinyl-1.

ow Norinyl-1 ters normal ndometrial responses– other possible otective mechanism

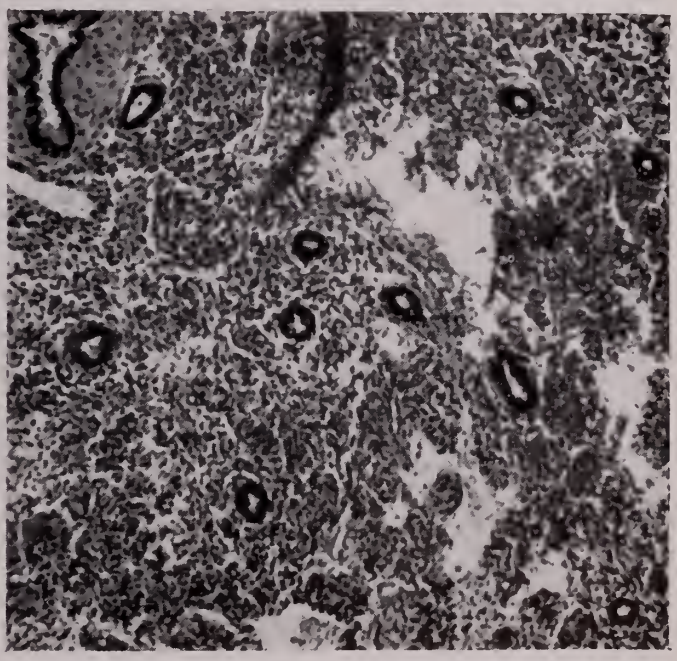
suppose that an ovum is released—as occurs in an nal, rare case—and somehow a sperm succeeds in ating the cervical mucus barrier. Should this come about, ditional action of Norinyl-1 may protect the patient nwanted pregnancy. The theory is that progestogen intake endometrial tissue unreceptive to implantation.

metrium of ated patient



ly, the endometrium progresses through erative phase stimulated by estrogen and a ry phase stimulated by progesterone. the secretory phase the endometrium is ve to the fertilized ovum.

Endometrium produced by Norinyl-1



When Norinyl-1 is administered its progestogen component—norethindrone—accelerates the secretory phase and suppresses glandular and vascular development.

new Norinyl-1® tablets

(norethindrone 1mg c mestranol 0.05mg.)

page for contraindications, precautions, side effects and dosage.

effective fertility control
on half the previous dosage

maintains ratio
of the established
norethindrone/mestranol
combination

lower cost

new Norinyl-1®

(norethindrone 1mg. c̄ mestranol 0.05mg.) tablets

Reduction of oral contraceptive dosage to lowest effective levels h become a well-accepted principle of conservative medical pract In keeping with this view, Norinyl is now available in a new stren in which *both* norethindrone and mestranol are reduced 50 perc Studies show that Norinyl-1 achieves fertility control with only 1 mg. of combined progestogen and estrogen per tablet.

Norethindrone was first reported for use as a progestational agen human beings in 1955. Norethindrone 2 mg. with mestranol 0.1 mg., an oral contraceptive, is currently in use by over 2,000,000 wom Clinical experience now establishes that Norinyl-1 also amply me the criteria of reliability and safety.*

*Symposium on Low-Dosage Oral Contraception, Palo Alto, Calif., July 15, 1965.

PRESCRIBING INFORMATION

Contraindications: 1. Patients with thrombophlebitis or with a history of thrombophlebitis or pulmonary embolism. 2. Liver dysfunction or disease. 3. Patients with known or suspected carcinoma of the breast or genital organs. 4. Undiagnosed vaginal bleeding.

Warnings: 1. Discontinue medication pending examination if there is sudden partial or complete loss of vision or if there is a sudden onset of proptosis, diplopia, or migraine. If examination reveals papilledema or retinal vascular lesions, medication should be withdrawn. 2. Since the safety of Norinyl-1 in pregnancy has not been demonstrated, it is recommended that for any patient who has missed two consecutive periods, pregnancy should be ruled out before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule, the possibility of pregnancy should be considered at the time of the first missed period. 3. Detectable amounts of the active ingredients in oral contraceptives have been identified in the milk of mothers receiving these drugs. The significance of this dose to the infant has not been determined.

Precautions: 1. The pretreatment physical examination should include special reference to breast and pelvic organs, as well as a Papanicolaou smear. 2. Endocrine and possibly liver function tests may be affected by treatment with Norinyl-1. Therefore, if such tests are abnormal in a patient taking Norinyl-1, it is recommended that they be repeated after the drug has been withdrawn for 2 months. 3. Under the influence of estrogen-progestogen preparations, preexisting uterine fibroids may increase in size. 4. Because these agents may cause some degree of fluid retention, conditions that may be influenced by this factor, such as epilepsy, migraine, asthma, cardiac, or renal dysfunction, require careful observation. 5. Although a cause and effect relationship has not been established, Norinyl-1 should be used with caution in patients with a history of cerebrovascular accident. 6. In relation to breakthrough bleeding, as in all cases of irregular bleeding per vaginam, nonfunctional causes should be borne in mind. In cases of undiagnosed vaginal bleeding, adequate diagnostic measures are indicated. 7. Patients with a history of psychic depression should be carefully observed and the drug discontinued if the depression recurs to a serious degree. 8. Any possible influence of prolonged Norinyl-1 therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study. 9. A decrease in glucose tolerance has been observed in a small percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be carefully observed while receiving Norinyl-1 therapy. 10. Because of the occasional occurrence of thrombophlebitis and pulmonary embolism in patients taking oral contraceptives, the physician should be alert to the earliest manifestations of the disease. A cause and effect relationship has not been demonstrated. 11. Because of the effects of estrogens on epiphyseal closure, Norinyl-1 should be used judiciously in young patients in whom bone growth is not complete. 12. The age of the patient constitutes no absolute limiting factor, although treatment with Norinyl-1 may mask the onset of the climacteric. 13. The pathologist should be advised of Norinyl-1 therapy when relevant specimens are submitted.

Side Effects: The following adverse reactions have been observed with varying incidence in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms, breakthrough bleeding, spotting, change in menstrual flow, amenorrhea, edema, chloasma, breast changes (tenderness, enlargement and secretion), loss of scalp hair, change in weight (increase or decrease), changes in cervical erosion and cervical secretions, suppression of lactation when given immediately postpartum, cholestatic jaundice, erythema multiforme, erythema nodosum, hemorrhagic eruption, migraine, rash (allergic), itching, rise in blood pressure in susceptible individuals, mental depression.

The following occurrences have been observed in users of oral contraceptives. A cause and effect relationship has not been established: thrombophlebitis, pulmonary embolism, neuroocular lesions.

The following laboratory results may be altered by the use of oral contraceptive creased bromsulphalein retention and hepatic function tests, coagulation test crease in prothrombin, factors VII, VIII, IX X), thyroid function (increase in PBI and nol extractable protein-bound iodine an crease in T^3 values), metapyrone test, preg diol determination.

Other side effects reported to have occ in association with use of this drug are ness, hirsutism, pains in legs, back, ches abdomen, dysuria, drowsiness, vagina charge, libido increased and decreased, tions, hypermenorrhea, hypomenor increased appetite, G.U. infections, va veins, abdominal fullness, acne, hea nervousness, allergies, blurred vision, p eyes, and itching in eyes. For *complete cl data*, see *package* insert.

Dosage and Administration: 1. One tab Norinyl-1 is administered orally for 20 beginning on day 5 of the menstrual (Count day 1 of the cycle as the first d menstrual bleeding.) Repeat this dosage ule for each cycle. 2. If no menstrual p occurs after a cycle of treatment (20 tabl which patient adhered to the schedule, t tient must be instructed to resume takir Norinyl-1 tablets 7 days after the previ day course was completed. For example, last pill of a previous cycle had been tak a Sunday, then a new cycle of treatment begin on the following Sunday. 3. In th partum woman, it is recommended th first cycle of treatment should begin on of the first menstrual cycle. However, Nc should not be administered during lactati

Availability: Norinyl-1 (norethindrone with mestranol 0.05 mg.)—Dispensers of 60 and bottles of 250 tablets.

norethindrone — an original steroid from

SYNTEX

LABORATORIES INC., PALO ALTO, CALIF.



in digestive disorders:

B and C vitamins aid therapy. Nausea, vomiting, and severe diarrhea may seriously interfere with the digestion and absorption of nutrients. STRESSCAPS capsules, containing therapeutic quantities of vitamins B and C, may help meet the needs of these patients. In digestive disorders, as in many stress conditions, STRESSCAPS vitamins aid therapy.



Stresscaps®

Stress Formula Vitamins Lederle

FOR PROFESSIONAL RECOMMENDATION ONLY

Each capsule contains:	
Vitamin B_1 (as Thiamine Mononitrate)	10 mg
Vitamin B_2 (Riboflavin)	10 mg
Vitamin B_6 (Pyridoxine HCl)	2 mg
Vitamin B_{12} Crystalline	4 mcgm
Vitamin C (Ascorbic Acid)	300 mg
Niacinamide	100 mg
Calcium Pantothenate	20 mg

Recommended intake: Adults, 1 capsule daily, for the treatment of vitamin deficiencies. Supplied in decorative "reminder" jars of 30 and 100; bottles of 500.

LEDERLE LABORATORIES, A Division of American Cyanamid Company, Pearl River, New York

692—6—3913

Lederle

Winthrop

announces

a breakthrough in the control of pain

Talwin®

brand of

pentazocine

(as lactate)

a potent, injectable non-narcotic

For every physician who has ever prescribed morphine

Talwin is the new potent non-narcotic injectable analgesic which is indicated for relief of all types and degrees of pain in acute and chronic disorders. Talwin 30 mg. is usually as effective an analgesic as morphine 10 mg. or meperidine 75 to 100 mg., but needs no narcotics controls. The duration of action of Talwin may sometimes be less than that of morphine.

Talwin is relatively free from adverse effects c morphine, such as constipation, urinary retentio or severe respiratory depression.

It has been used, in varying dosages, in ov 12,000 patients for relief of pain of medical di orders, of active labor and postoperative pai also for preoperative or preanesthetic medicatio and as an adjunct to anesthesia.

A brochure incorporating analyzed information on Talwin is available. The completeness of the information will permit you to evaluate the role Talwin can play in your practice.

You can depend on Talwin to relieve pain:

WHATEVER the intensity of the pain
the cause of the pain
the site* of the pain
the duration of the pain
the chronicity of the pain
the age† of the patient

Talwin does not require a narcotics prescription

The World Health Organization Expert Committee c Dependence-Producing Drugs concluded that "...the was no need at this time for narcotics control of pent zocine [Talwin] internationally or nationally." (*WH Tech. Rep. Ser.*, No. 343, 1966, p. 6.)

It is our sincere belief that the discovery of Talwin b Winthrop Laboratories will be of great value to you an your patients for whom you may have to prescribe potent analgesic.

*Talwin should not be used for patients with increased intracranial pressu head injury or pathologic brain conditions.

†Until sufficient experience is gained, it should not be administered to childr under 12 years of age.

lwin—brand of pentazocine (as lactate)

traindications: *Inereased Intraeranial Pressure, Head Injury, athologie Brain Conditions in whieh elouding of sensorium is sirable.* Talwin (brand of pentazocine) should not be adminis- l in these cases, since drug-induced sedation, dizziness, nausea, spiratory depression could be misleading.

autions: *Pregnaney.* No teratogenic or embryotoxic effects butable to the use of Talwin have been seen in extensive repro- ive studies in animals; however, like all new drugs, Talwin ld be given with caution to pregnant women. A large number atients in labor have received the drug with no adverse reac- other than those that occur with commonly used strong gesics. However, as with other strong analgesics, Talwin should sed with caution in women delivering premature infants.

ulatory Patients. Since sedation, dizziness, and occasional noria have been noted, ambulatory patients should be warned o operate machinery, drive cars, or unnecessarily expose them- s to hazards.

ain Respiratory Conditions. The possibility that Talwin (brand entazocine) may cause respiratory depression should be con- ed in treatment of patients with bronchial asthma. Talwin d of pentazocine) should be administered only with caution in low dosage to patients with respiratory depression (e.g., other medication, uremia, or severe infection), obstructive iratory conditions, or cyanosis.

ents Dependent on Nareoties. Because Talwin is a narcotic- gonist, patients dependent on narcotics and receiving Talwin occasionally experience certain withdrawal symptoms. Talwin ld be given with special caution to such patients. It has been rved that some patients previously given narcotic-analgesics ne month or longer had mild withdrawal symptoms when the was replaced with the analgesic, Talwin. After a short period djustment the subjects were usually able and willing to con- e taking Talwin, and relief of pain was satisfactory.

addicted Patients Reeeiving Nareotics. Symptoms believed to ndicative of antagonism to the opiate may be observed rarely administration of Talwin to patients receiving opiates for a t time. Intolerance or untoward reactions are seldom observed administration of Talwin to patients who have received single s or who have had limited exposure to narcotics.

nired Renal or Hepatie Funetion. Although laboratory tests not indicated that Talwin (brand of pentazocine) causes or ases renal or hepatic impairment, the drug should be adminis- l with caution to patients with such impairment. Extensive disease appears to predispose to greater side effects (e.g., ed apprehension, anxiety, dizziness, sleepiness) from the usual cal dose, and may be the result of decreased metabolism of the by the liver.

cardial Infaretion. As with all drugs, Talwin (brand of penta- ne) should be used with caution in patients with myocardial rction who have nausea or vomiting.

ry Surgery. Until further experience is gained with the effects lwin on the sphincter of Oddi, the drug should be used with ion in patients about to undergo surgery of the biliary tract.

rse Effects: Talwin is relatively free from the undesirable side ts associated with morphine, such as constipation, urinary re- on, or severe respiratory depression. Furthermore, Talwin uces less nausea, vomiting, and diaphoresis than meperidine.

er 12,000 patients who received Talwin intramuscularly, sub- neously, or intravenously, nausea, the most frequent adverse t, occurred in approximately 5.0 per cent. In decreasing order currence were vertigo, dizziness or lightheadedness; vomiting; euphoria. Respiratory depression was reported as an adverse ion in 1.0 per cent.

incidence of each of the other adverse effects was well below per cent: constipation, circulatory depression, diaphoresis, uri- retention, alteration in mood (nervousness, apprehension, ession, floating feeling), hypertension, sting on injection, head- ache, dry mouth, flushed skin including plethora, altered uterine contractions during labor, dermatitis including pruritus, dreams, paresthesia, and dyspnea occurred rarely after administration of Talwin (brand of pentazocine). Furthermore, each of the following adverse reactions occurred in less than 0.1 per cent: tachycardia, visual disturbance (blurred vision, diplopia and nystagmus), hallucinations, disorientation, weakness or faintness, muscle tremor, chills, allergic reactions including edema of the face, taste alteration, insomnia, diarrhea, cramps, and miosis; laryngospasm in one patient.

Talwin has not produced severe respiratory embarrassment in adults (never apnea), even with large amounts. A small number of newborn infants whose mothers received Talwin during labor had transient apnea. The incidence of temporary diminution in the rate or strength of uterine contractions is low after administration of Talwin, similar to that following meperidine hydrochloride. (In reporting no interference with normal labor in patients receiving Talwin, one investigator further stated that the drug may increase uterine activity.) Generally, no significant fetal heart rate change occurs.

Laboratory tests of blood and of liver and kidney functions have revealed no significant abnormalities. A minimum and probably insignificant increase in the per cent of eosinophils in peripheral blood counts and bone marrow occurred occasionally.

Talwin is well tolerated by patients with diabetes mellitus, and no changes in insulin requirements have been observed.

Dosage and Administration: *Adults, Exeluding Patients in Labor.* Average recommended single parenteral dose is 30 mg., by intramuscular, subcutaneous, or intravenous route; may be repeated every three to four hours. Pain has been relieved in most patients with not more than three doses daily. Infrequently, selected patients have received single doses as high as 60 mg. *Patients in Labor.* A single, intramuscular 30 mg. dose has been most commonly administered. An intravenous 20 mg. dose has given adequate pain relief to some patients in labor when contractions become regular, and this dose may be given two or three times at two- to three-hour intervals, as needed.

Children Under 12 Years of Age. Since clinical experience in children under twelve years of age is limited, the use of Talwin (brand of pentazocine) in this age group is not recommended.

Duration of Therapy. Patients with chronic pain who received Talwin for prolonged periods (e.g., over 300 days) experienced no withdrawal symptoms even when administration was stopped abruptly; furthermore, there was no tolerance to the analgesic effect.

CAUTION. Talwin should not be mixed in the same syringe with soluble barbiturates because precipitation will occur.

Treatment of Overdosage or Respiratory Depression. Talwin has not produced apnea or severe respiratory embarrassment in adults, even in large doses. Occasionally, however, moderate respiratory depression may occur. Means of maintaining proper oxygenation should be available in case of overdosage or respiratory depression, and methylphenidate (Ritalin®) should be administered parenterally. The usual narcotic-antagonists, such as nalorphine, are not effective respiratory stimulants for depression due to Talwin.

How Supplied: *Ampuls of 1 ml.*, containing Talwin® (pentazocine) as lactate equivalent to 30 mg. base and 2.8 mg. sodium chloride, in Water for Injection. Boxes of 10, 25, and 100.

Multiple dose vials of 10 ml., each 1 ml. containing Talwin (pentazocine) as lactate equivalent to 30 mg. base, 2 mg. acetone sodium bisulfite, 1.5 mg. sodium chloride, and 1 mg. methylparaben as preservative, in Water for Injection. Boxes of 1.

The pH of Talwin solutions is adjusted between 4 and 5 with lactic acid and sodium hydroxide.

Winthrop

Winthrop Laboratories, New York, N.Y. 10016

(1150M)

When moderate to severe anxiety strikes home...

(the agitated geriatric)

His teen-age granddaughter won't invite friends home because of his outbursts.



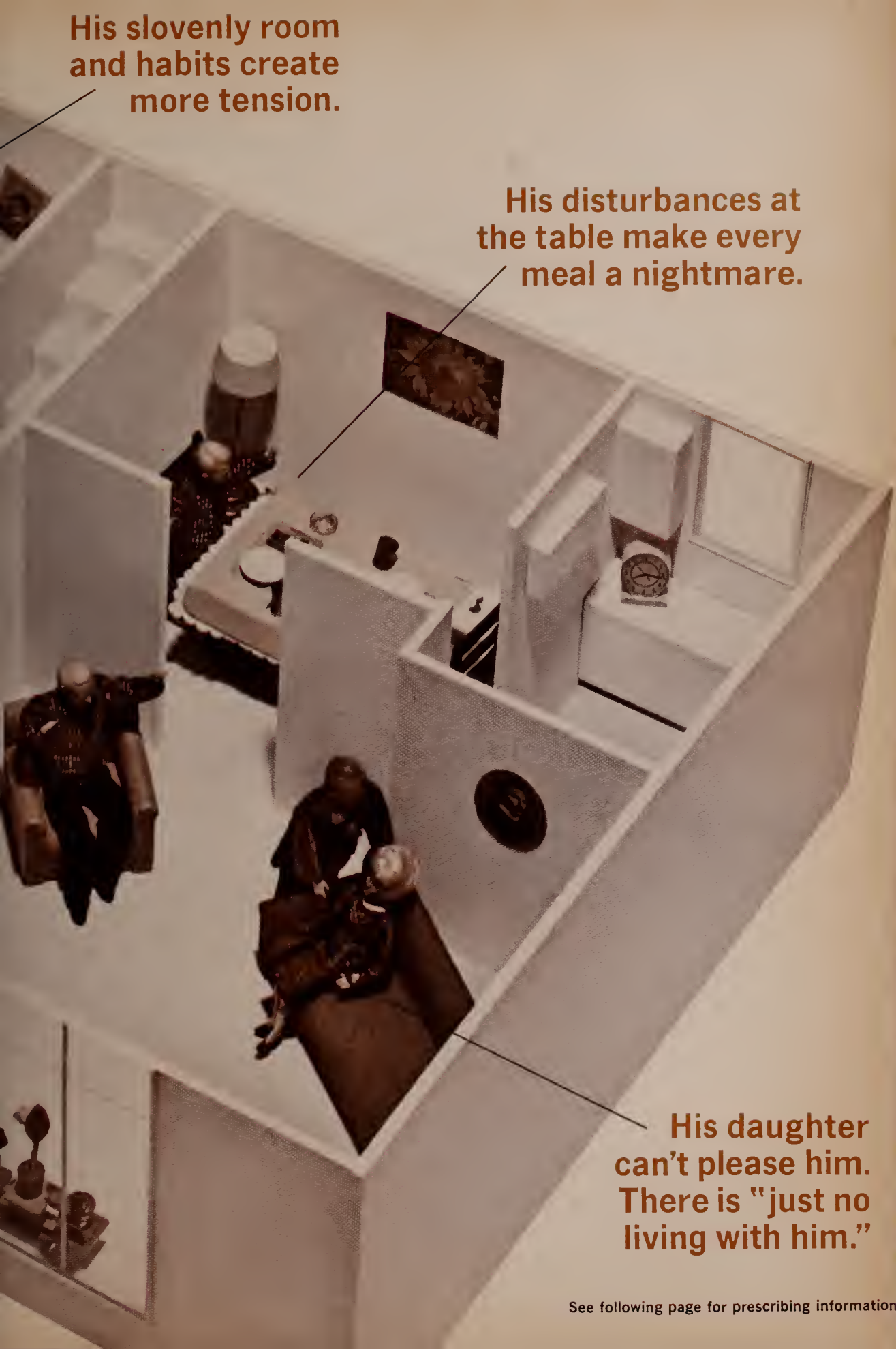
for moderate to severe anxiety

Mellaril®

(thioridazine)

25 mg. t.i.d.

SANDOZ



See following page for prescribing information

When moderate to severe anxiety strikes home...

Anxiety that seriously interferes with the individual's performance at work, at home, or in the community may be regarded as moderate to severe in degree.

Mellaril often recommends itself to the treatment of moderate to severe anxiety because it

- helps control the most frequent symptoms: marked tension, agitation, apprehension, restlessness, hypermotility
- often alleviates anxiety-induced somatic complaints
- frequently helps strengthen emotional resources
- helps the patient maintain realistic contact with environment, closer harmony with family

Thus, when you consider the anxiety moderate to severe... consider Mellaril.

Contraindications: Severely depressed or comatose states from any cause, and in association with or following MAO inhibitors; severe hypertensive or hypotensive heart disease.

Precautions: Hypersensitivity reactions (e.g., leukopenia, agranulocytosis) and convulsive seizures are infrequent. Pigmentary retinopathy has been observed where doses in excess of those recommended were used for long periods of time. May potentiate central nervous system depressants, atropine, and phosphorus insecticides. Where complete mental alertness is required, administer the drug cautiously and increase dosage gradually. In addition, orthostatic hypotension (especially in female patients) has been observed. Epinephrine should be avoided in treatment of drug-induced hypotension.

Side Effects: Pseudoparkinsonism and other extrapyramidal disorders are infrequent; drowsiness, especially in high doses early in treatment, may occur; nocturnal confusion, dryness of the mouth, nasal stuffiness, headache, peripheral edema, lactation, galactorrhea, and inhibition of ejaculation are noted on occasion; photosensitivity and other allergic skin reactions may occur but are extremely rare.

Before prescribing, see package insert for full product information.

for moderate to severe anxiety

Mellaril®
(thioridazine)
25 mg. t.i.d.

SANDOZ

mudrane®

for

- EMPHYSEMA
- ASTHMA
- CHRONIC BRONCHITIS
- BRONCHIECTASIS

The fast-disintegrating uncoated tablet gives relief in 15 minutes

Each tablet contains:

Potassium Iodide	195 mg
Aminophylline	130 mg
Phenobarbital, Caution: May be habit forming...	21 mg
Ephedrine HCl	16 mg

FEDERAL LAW PROHIBITS
DISPENSING WITHOUT PRESCRIPTION

Precautions: Usual for aminophylline-ephedrine-phenobarbital. Iodides may cause nausea, long use may cause goiter. Discontinue if symptoms of iodism develop.

Iodide contraindications: tuberculosis, pregnancy.

DOSAGE

One tablet, with full glass of water, 3 or 4 times daily.

Dispensed in bottles of 100 and 1000 tablets.

MUDRANE GG—Formula, dosage and package identical to Mudrane—*except*—100 mg. glyceryl guaiacolate replaces the potassium iodide. The value of Mudrane cannot be enjoyed by a small group in which K.I. is contraindicated. Mudrane GG is prepared for this group.

MUDRANE GG ELIXIR—Four 5 cc teaspoonfuls is equivalent to one Mudrane GG tablet. Dosage adjusted to age and weight of child. Mudrane GG Elixir is for pediatric patients and those who think they cannot swallow tablets. Dispensed in pint and half gallon bottles.

WM. P. POYTHRESS & CO., INC.
RICHMOND, VIRGINIA 23217
Manufacturers of ethical pharmaceuticals since 1856



The Medical Detective

The Sunday Gardener

With our favorable climate and adequacy of rain, the weekend in Florida is often devoted to the beautification of one's property, and thus, gardening is an important activity. The lawn becomes target for the aggressive gardener and all sorts of devices have been utilized to cut the grass. With the old-fashioned hand lawnmower being replaced by the motorized version, additional problems have arisen. These additional problems, for the most part, are related to injuries of the extremities, but on occasion serious accidents have occurred which prove fatal. These fatal accidents have been related to the fact that occasionally a lawnmower may stir up the ground over which it is riding and stones, pieces of metal or glass may become missiles hurled by the whirling blades.

An interesting problem arose on one occasion where an energetic garden enthusiast went out one Sunday evening to trim his lawn and found one of the tires on his power lawnmower partially deflated. He went to a service station to use a combination gauge and air hose to inflate the mower tire. A loud explosion was heard soon afterward. The service station attendant was pumping gas at the time, thought it was a backfire, and gave it no concern. It wasn't until the attendant went to the side of the garage several minutes later that he discovered the customer lying on the ground next to the air hose, face down, in a pool of blood. It was reasoned that the man may have had a heart attack or stroke and hurt himself while falling. The police were called and an ambulance soon arrived. The ambulance attendant stated he believed the man was still alive. Upon arrival at the emergency room of the local hospital, however, the man was pronounced dead.

Because of the marked bleeding, the emergency room doctor believed the case should be investigated as a possible accident with injury as a complication of a natural disease process. The body was removed to the hospital morgue and the following morning the pathologist and the local medical examiner proceeded with the investigation.

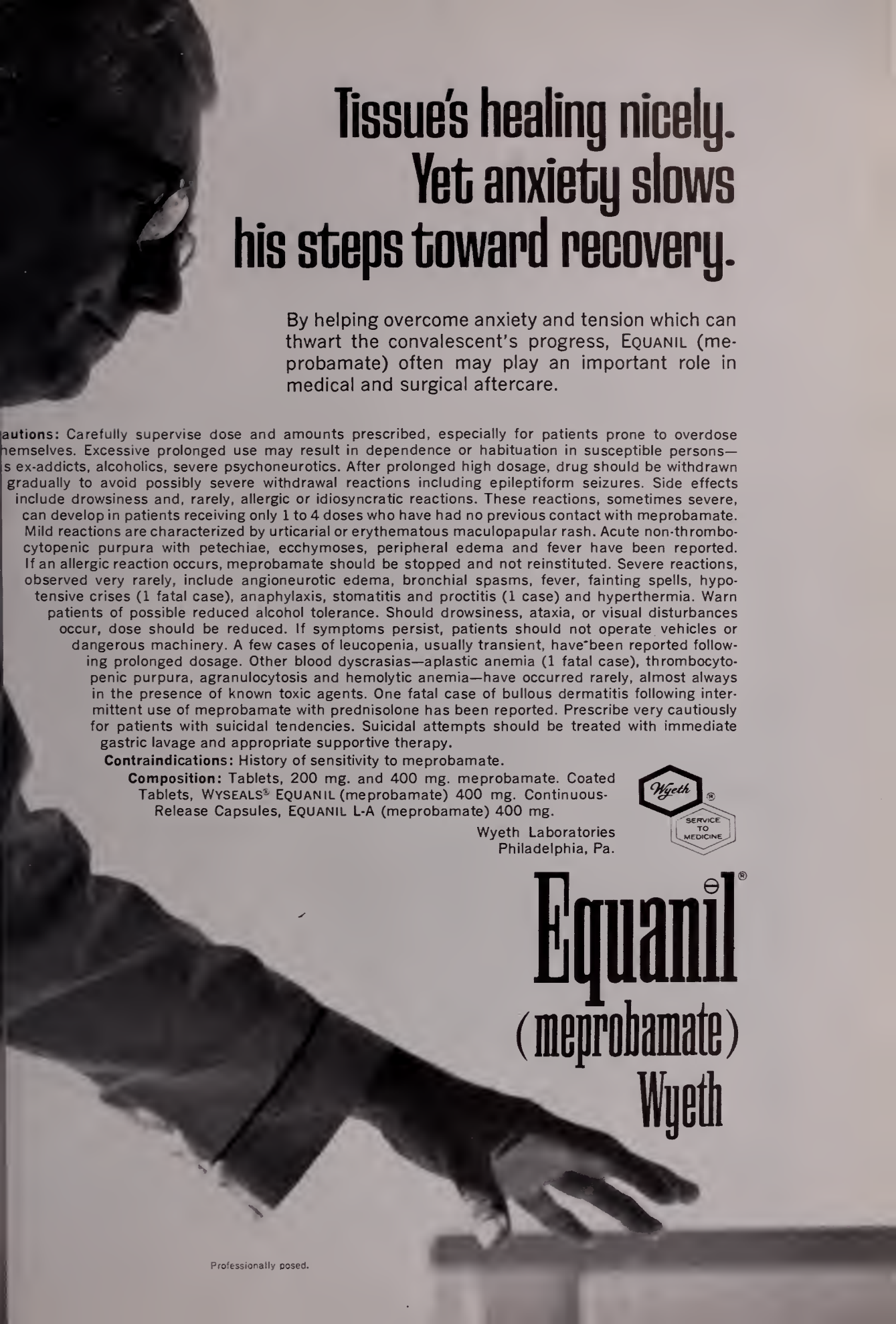
External examination revealed a cut present over the left eyebrow. A hole which was deep enough to be probed was also present in this area. The pathologist thought this possibly a bullet hole and x-rays revealed a foreign object within the cranial cavity which turned out to be a small piece of bolt. There was a considerable amount of intracranial bleeding and destruction of brain tissue. Further examination of the body failed to reveal any evidence of an acute natural disease process which might have produced sudden demise.

The police returned to the scene of the accident, and their examination of the lawnmower revealed that the rim of the tire had apparently been expanded by excessive pressure and six small bolts holding two parts of the rim together had been sheared off, thus releasing both the rim and the bolts at high speed. The man's head was probably not more than 18 inches from the tire at the time.

This is no doubt a preventable accident, a result of a do-it-yourself impulse on the part of the deceased. The simple matter of asking the station attendant how much pressure the tire required would certainly have helped to prevent this unfortunate accident.

WILLIAM G. ECKERT, M.D.





Tissue's healing nicely. Yet anxiety slows his steps toward recovery.

By helping overcome anxiety and tension which can thwart the convalescent's progress, EQUANIL (meprobamate) often may play an important role in medical and surgical aftercare.

autions: Carefully supervise dose and amounts prescribed, especially for patients prone to overdose hemselves. Excessive prolonged use may result in dependence or habituation in susceptible persons—s ex-addicts, alcoholics, severe psychoneurotics. After prolonged high dosage, drug should be withdrawn gradually to avoid possibly severe withdrawal reactions including epileptiform seizures. Side effects include drowsiness and, rarely, allergic or idiosyncratic reactions. These reactions, sometimes severe, can develop in patients receiving only 1 to 4 doses who have had no previous contact with meprobamate. Mild reactions are characterized by urticarial or erythematous maculopapular rash. Acute non-thrombocytopenic purpura with petechiae, ecchymoses, peripheral edema and fever have been reported. If an allergic reaction occurs, meprobamate should be stopped and not reinstituted. Severe reactions, observed very rarely, include angioneurotic edema, bronchial spasms, fever, fainting spells, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case) and hyperthermia. Warn patients of possible reduced alcohol tolerance. Should drowsiness, ataxia, or visual disturbances occur, dose should be reduced. If symptoms persist, patients should not operate vehicles or dangerous machinery. A few cases of leucopenia, usually transient, have been reported following prolonged dosage. Other blood dyscrasias—aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis and hemolytic anemia—have occurred rarely, almost always in the presence of known toxic agents. One fatal case of bullous dermatitis following intermittent use of meprobamate with prednisolone has been reported. Prescribe very cautiously for patients with suicidal tendencies. Suicidal attempts should be treated with immediate gastric lavage and appropriate supportive therapy.

Contraindications: History of sensitivity to meprobamate.

Composition: Tablets, 200 mg. and 400 mg. meprobamate. Coated Tablets, WYSEALS® EQUANIL (meprobamate) 400 mg. Continuous-Release Capsules, EQUANIL L-A (meprobamate) 400 mg.

Wyeth Laboratories
Philadelphia, Pa.

Wyeth® SERVICE TO MEDICINE

Equanil®
(meprobamate)
Wyeth

Professionally posed.

easy does it!

tear, moisten, compare–that's all!





Scientific Section

Fatal Pneumocystis Pneumonia in an Adult

GIUSEPPE C. CASTELLANO, M.D. and EUGENE H. RUFFOLO, M.D.

Pneumocystis pneumonia is extremely familiar to European pediatricians, who have recognized it for many years as a fatal form of infantile pneumonia, especially in the premature and debilitated infant population of institutions. This recognition is well borne out by the occurrence of an estimated 700 cases in Switzerland between 1941 and 1949.[1] Recognized instances in adults, however, remain rare. In 1965, Esterly[2] described six cases bringing the total to 25 adult cases recorded as occurring in the United States. In Gilbert's[3] collection of 33 adult cases from the world literature, all but three patients had chronic and fatal diseases, particularly lymphoreticular malignant disease, and about one half of these had received prolonged steroid therapy.

The following report is that of an adult male who died of pneumocystis pneumonia eight years after diagnosis and subsequent treatment of chronic lymphocytic leukemia.

From the Department of Pathology, Tampa General Hospital.

Report of Case

A retired 69 year old white man was admitted to the hospital because of cough, nausea, fever and chills, dysuria, nocturia and back and chest pain of several days' duration. A diagnosis of chronic lymphocytic leukemia had been established eight years previously and the patient had been referred to the hematology clinic two years previous to this admission. When first seen in the hematology clinic, the white blood cell count was 24,000 cu.mm., 80% of which were mature lymphocytes. The bone marrow examination at that time was consistent with the diagnosis of chronic lymphocytic leukemia. During the past five years exacerbations had been well controlled by increased dosages of chemical agents, steroids and transfusions. Therapy included radioactive phosphorus (P32), chlorambucil, cyclophosphamide and steroids. Positive findings, other than temperature elevated to 104 F., were limited to the chest wherein rales were detected posteriorly and bilaterally. The admitting diagnoses were chronic lymphocytic leukemia and bilateral bronchopneumonia. Laboratory tests included the following: Hemoglobin value, 10.6 Gm./100 ml.; red blood cells, 2.8 million/cu.mm.; white blood cells, 77,500/cu. mm. with 100% lymphocytes; hematocrit reading 32; mean corpuscular hemoglobin 36; platelets 52,330/cu.mm.; urinalysis not remarkable; blood urea nitrogen, 48 mg.%.

Roentgenographic examination of the chest revealed an increased prominence of the bronchovascular markings in each lung field. Patchy areas of increased parenchymal density were present in the left midlung field and in both bases and these were interpreted as patchy pneumonia



Fig. 1.—Chest x-ray revealing patchy pneumonia involving both bases, left middle and right upper lung fields.

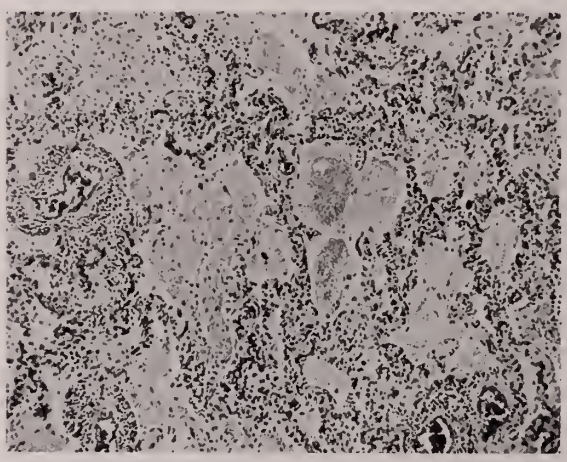


Fig. 2.—The pulmonary alveoli are filled with an amorphous, foamy, pink material. The alveolar septae exhibit an infiltrate of mature lymphocytes as well as plasma cells (Hematoxylin and Eosin x 100).

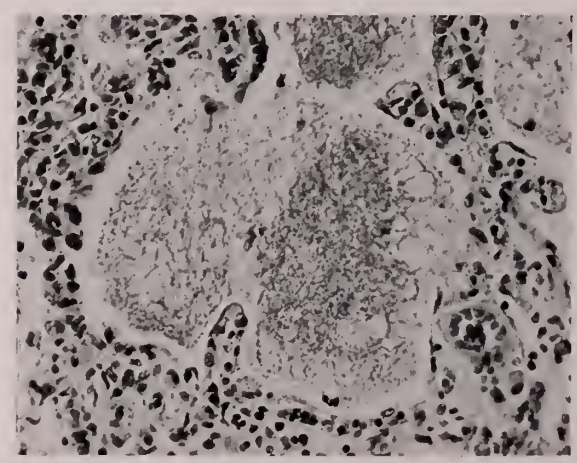


Fig. 3.—Within the characteristic foamy alveolar contents is a suggestion of clear spaces as well as punctate densities (Hematoxylin and Eosin x 400).

(fig. 1). On the fourth day of hospitalization the patient was not responding to antibiotic treatment, and a repeat chest plate showed that the pneumonic process had extended and, for the first time, the right upper lung field was involved. The patient continued to be dyspneic and cyanotic and died of respiratory insufficiency on the fifteenth day of hospitalization, eight years after the diagnosis of chronic lymphocytic leukemia had been established.

At autopsy the lungs were heavy (1,250 Gm.), maintained their shape after removal from the thorax and consolidation of both lower lobes and right middle and upper lobe was present. The cut surfaces were tan, edematous and of a firm but spongy consistency. Routine (hematoxylin and eosin) microscopic sections revealed distended alveoli, filled with an amorphous, foamy acidophilic material containing a few macrophages (figs. 2 and 3). An intense perivascular and alveolar septal lymphocytic infiltration was noted. These findings were suggestive of pneumocystis carinii pneumonia. The intra-alveolar microorganisms, clearly evident with Gomori methenamine silver stain (fig. 4), were seen as black cystic structures, the size of which varied from four to seven micra and the shape varied from round to ovoid to a crescent configuration. The capsules of the "cysts" were thin and formed a black areola to an intracystic structure (possibly vegetative form), characterized by two black dots, at times taking the form of two parentheses ("()") facing each other. The rest of the autopsy revealed a lymphocytic infiltrate in the lymph nodes, liver, spleen and kidneys as well as the lungs. The heart weighed 320 Gm. and the coronary arteries showed a Grade II sclerosis. Other findings were not remarkable.

Discussion

Although the organism, pneumocystis carinii, has been considered both as a fungus and as a protozoal parasite, the latter thought is at present more prevalent. The history of its discovery, classification and nomenclature is well discussed by Spencer.[1] The details of its life cycle are, at this time, unknown. As previously stated, most adult cases have occurred as a complication of an underlying malignant lymphoreticular disease including lymphoma, leukemia and myeloma. An exception was reported in detail by Kaftori,[5] who described

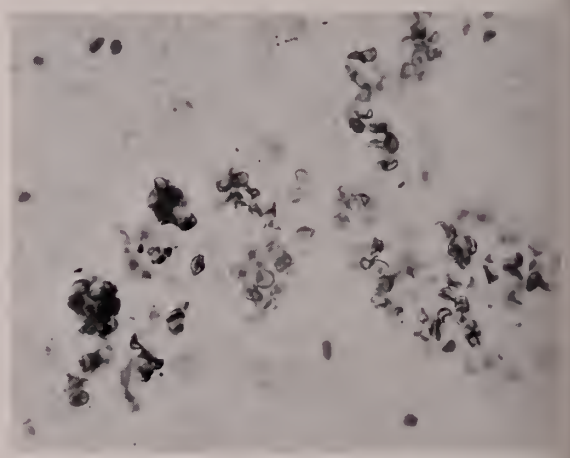


Fig. 4.—The oval, crescent cysts containing parenthesis-like inclusions, characteristic of pneumocystis carinii, are well depicted by Gomori methenamine silver stain (X 1000).

a primary fatal case in a 23 year old woman. The autopsy failed to reveal an underlying disorder. In Kaftori's case, as in ours, the pneumocystis pneumonia was considered to be the immediate cause of death and not an incidental finding.

The usual incidence in premature and or debilitated infants, older children with hypogammaglobulinemia, adults with malignant disease having received radiation, prolonged cytotoxic or steroid therapy, all suggest a common denominator of altered host immune response mechanisms. Cytomegalic inclusion disease not only is prevalent in similar situations but occurs concomitantly in 25% of pneumocystis cases.[3]

The diagnosis of pneumocystis pneumonia in an adult, although rare, should be considered when encountering antibiotic-resistant pneumonia complicating a clinical situation as previously described. Esterly[2] suggested the staining of sputum smears for the presence of these microorganisms, thereby establishing a possible antemortem diagnosis. In the event of an antemortem diagnosis of pneumocystis, antiprotozoal agents such as pentamidine isethionate may prove to be effectual therapy. Robbins[6] described the case of an eight year old girl with congenital hypogammaglobulinemia and complicating pulmonary disease. The antemortem diagnosis of pneumocystis pneumonia was confirmed by lung biopsy and she was apparently cured by a course of pentamidine isethionate. Anemia with megaloblastic bone marrow features developed during therapy and subsided three weeks after discontinuing the antiprotozoal agent.

Summary

A rare instance of fatal pneumocystis carinii pneumonia in an adult with an eight year history of chronic lymphocytic leukemia is described. The gross and microscopic anatomic findings as well as roentgenographic illustrations are presented.

The microorganism is most probably an opportunistic protozoan which proliferates in the alveolar spaces of debilitated patients, usually because of lymphoreticular malignant disease, who are recipients of long term cytoxic and steroid therapy. An altered host immune mechanism is implicated. The occurrence of an antibiotic-resistant pneumonia in this clinical situation should suggest the possibility of pneumocystis pneumonia. Because of the beneficial effects reported with the use of antiprotozoal agents, such as pentamidine isethionate, active attempts at antemortem diagnosis are encouraged.

References

1. Deamer, W. C., and Zollinger, H. U.: Interstitial "Plasma Cell" Pneumonia of Premature and Young Infants, Pediatrics 12:11-22 (July) 1953.
2. Esterly, J. A., and Warner, N. E.: Pneumocystic Carinii Pneumonia, Arch. Path. 80:433-441 (Nov.) 1965.
3. Gilbert, C. F.; Fordham III, C. C., and Benson, W. R.: Death Resulting From Pneumocystis Pneumonia in an Adult, Arch. Int. Med. 112:158-163 (Aug.) 1963.
4. Spencer, H.: Pathology of the Lung, New York: MacMillan Co., 1962, pp. 251-254.
5. Kaftori, J. K.; Bassan, H.; Gellei, B., and Griffel, B.: Pneumocystis Carinii Pneumonia in the Adult. Report of a Primary Case, Arch. Int. Med. 109:438-446 (Apr.) 1962.
6. Robbins, J. B.; Miller, R. H.; Arean, V. M., and Pearson, H. A.: Successful Treatment of Pneumocystis Carinii Pneumonitis in a Patient with Congenital Hypogammaglobulinemia, New England J. Med. 272:708-713 (Apr.) 1965.

Dr. Ruffolo, Tampa General Hospital, Tampa 33606.



Collaborative Management of Ulcerative Colitis

LEON MARDER, M.D.

Ulcerative colitis in adults and children remains one of the most challenging puzzles in medicine. The somatic pathophysiology is not well understood, and in spite of more than 35 years of psychiatric interest beginning with Murray[1] in 1930, the delineation of the psychological process remains incomplete. Review of the literature continues to reveal conflicting opinion as to the nature of psychosomatic illnesses in general. Although the relationships between psychological and physiological variables have been well established in a general sense, the basis for specific psychosomatic disease is subject to a variety of highly controversial hypotheses. Recently, question has been raised whether psychosomatic illness represents a true entity or whether it is merely a concept.[2] Various authors have suggested that psychosomatic illness may be based on a depressive reaction in which the psychosomatic symptomatology is masking the underlying symptoms of depression. Fear of loss of the significant love object, either real or fantasied, represents the important stressful event which leads to the development of psychosomatic disorders.[3-9]

A view concerning a theory of etiology in ulcerative colitis as proposed by Groen[10] in 1956 has provided a more realistic approach to this disease. This theory suggests that certain individuals possess in their personality structure a core of characteristics (partly inherited, partly developed under the influence of certain youth situations) which make them more vulnerable to conflicts which threaten their emotional security. These conflicts are usually with "key persons" in their close environment. In acute cases, the disease breaks out after a latent period of not more than 24 to 48 hours following a conflict which is characterized by a course, usually verbal humiliation, often in the presence of others, which hurts the patient's self respect and leaves him defeated and humiliated. Often this offense refers to his own concepts of sexual inadequacy. In cases of insidious onset, the conflict consists of a series of minor offenses of a similar type appearing in the life situation, from which he cannot free himself. Whether the feelings of humiliation and defeat are conscious or not, the emotional trauma is not discharged in fighting, weeping, speech or action. In other words, the individual does not respond by adequate or pathological outwardly directed aggressive or defensive behavior. This inhibition of a behavioral discharge converts the external personal trauma into an internal conflict situation. It is this emotional conflict within the individual which, through mechanisms and along pathways not clearly understood, produces the changes in the colonic mucosa that are responsible for the clinical and pathological signs of the disease.

There is no doubt that the mother-child symbiotic relationship determines the particular personality development of the individual and produces his vulnerability to separation. Engle[11-15] in his classical studies of over 700 patients reported similar findings, and others working in the field speak of the special dependency relationship with its loss, real or fantasied, which then mobilizes primitive behavior patterns accompanied by depression, rage and bowel symptoms. When this loss is openly accepted and actively worked through with the normal mourning period, the ulcerative colitis is avoided. When the patient's

This work was performed and completed while Dr. Marder was a N.I.M.H. Career Teacher at the University of Florida College of Medicine, Gainesville. Dr. Marder is presently Associate Professor of Psychiatry, University of Southern California School of Medicine.

anger is openly expressed without guilt, there are no accompanying somatic expressions. Expression of anger does not come easily for ulcerative colitis patients, however, and frequently they strive to suppress aggressive expression because of the conscious or unconscious guilt. It is because of this intense, ambivalent interdependent relationship with a key figure that they are unable to express aggressive thoughts or behavior and they frequently complain of headache. In general, headaches do not occur when the colitis is active and the patient depressed. Headaches do occur, however, when the patients feel in control and have taken an aggressive stand in regard to the challenging situation. Although stress and anxiety are frequently considered to be synonymous, anxiety has little or no effect on the colitis in the course of the patients studied in most of these series.

The prognostic implication of psychiatric diagnosis in ulcerative colitis is one which has only recently been presented.[16] The majority of articles published examine the effect of psychotherapy upon the disease process but fail to consider the psychiatric diagnosis of the patient. Long term follow-up studies reveal that patients diagnosed as being schizophrenic have a decidedly less favorable prognosis than those diagnosed as being nonschizophrenic. There is no significant variation in the course of the colitis among control patients, however, whether they were diagnosed as having psychoneurosis, personality disorder or no overt psychiatric disturbance. Ninety per cent of the schizophrenic patients first manifested obvious emotional disturbance in conjunction with the onset of subsequent exacerbation of the colitis, and 65% experienced acute psychotic episodes coinciding in time with a physiological flareup. The incidence of psychosis occurring directly preoperatively or postoperatively was 52%.

More recently in studying family structure in patients with ulcerative colitis, Jackson and Yalom[17] reveal that the disease is not a specific etiological result of certain family interactional patterns, but that this disorder enters into the family problems, and the family problems enter into the prognosis of the patient. There appears to be a similarity of behavior amongst families of ulcerative colitis patients. These families are severely socially restricted and actively restrict each other in the range of permissible behavior. The term pseudomutuality best describes the apparently false solidarity of these families.

Material

A review of cases of ulcerative colitis seen at The University of Florida Teaching Hospital from July 1958 through December 1962 showed that 34 patients were admitted with this disease. There were 15 patients requiring surgery, with the majority of the operative procedures being total colectomy and ileostomy, and 19 patients treated nonsurgically. A three year follow-up in both of these groups revealed that there were two postoperative deaths, and one death in this period due to a metastatic carcinoma of the colon. The surgical group included 12 of the 15 doing well postoperatively. The nonsurgical group showed 15 patients with a relatively good posthospitalization course. During this period of time, three patients were referred for psychiatric consultation, only one of whom was eventually admitted and treated as an inpatient on the psychiatric unit. Thirty ulcerative colitis patients were admitted between January 1963 and December 1964. Ten patients were treated surgically with the major procedure again being total colectomy and ileostomy, and there were two postsurgical deaths. Twenty patients were treated nonsurgically, and follow-up studies at this time have not been completed. During this same period of time, six patients were referred for psychiatric consultation and three were continued in outpatient psychotherapy.

Treatment

In the past each of us with clinical experience has observed that one form of therapy, medical, surgical or psychiatric, usually receives emphasis at the expense of the others. Or, at best, the various forms may operate simultaneously but remain compartmentalized and separate from each other.[18] Thus, physicians find it impossible to arrive at mutually accepted decisions when they remain isolated from each other in separate offices and communicate via the consultation form. Many of us pay lip service to the idea of coexistent psychic and somatic forces in disease; but in practice, dichotomous opinions are presented on separate pages of a chart which cannot by themselves unite into an operational system. This may be accomplished by utilizing what has been defined as a comprehensive medical approach offering physicians, other specialists and nurses

communication channels with the opportunity for each individual to develop insight into what his colleagues have been saying and their reasons for saying it. The most significant feature of comprehensive medicine is that it is patient-oriented as opposed to disease-oriented. The collaborative atmosphere of the team conference encourages the patient to talk about himself, his problems, his ideas and his sickness. Our experience demonstrates that an understanding explanation to the patient of the origin of his illness or the emotional effects of stress, anxiety or depression on his exacerbations is effective in starting him to handle the problems realistically.

Team Concept

The creation of a team does not eliminate interdisciplinary problems. Neither do these problems solve themselves automatically. To put the team concept and a coordinated collaborative program into action, and to give direction to a day-to-day operation, one person must act as leader. There are times when misunderstandings between team members must be resolved; at other times there are aspects of treatment that require coordination, and still other times when decisions must be made. Without such leadership, the flexibility which is absolutely necessary in these cases could result in chaos. We have been able to establish a team which functions so that each member is responsible for a well defined area of patient management. The psychiatrist in this setting becomes able to deal with large numbers of patients using aggressive, short term techniques with limited goals, is able to work in a medical setting, and tolerates therapeutic limitations inherent under these conditions. The surgeon no longer views the disease in terms of appearance of the bowel and the physical appearance of the patient. The internist no longer views the patient as merely requiring the right combination of chemical drugs and dietary restrictions. Instead we have been able to value the patient on the basis of his being a person who is sick rather than a patient who presents a particular type of illness.

Utilizing this collaborative team approach we no longer consider surgical intervention as a failure or as an alternative to medical treatment or psychotherapy. In fact, it is no longer considered an interruption since the incidence of ulcerative colitis in the remaining bowel alone warrants the continued efforts of the team. Furthermore, the period following operation presents crucial problems in which it is essential that the surgeon, psychiatrist and physician work together.

A typical case is that of a 17 year old single white woman who had been troubled with ulcerative colitis for approximately one year, and had been recently hospitalized because of the extreme deterioration in her condition. The oldest of three children; she had a younger brother and sister. Her father was aloof toward his wife and children and dealt with problems by withdrawing into his study where he could work in peace and quiet. The mother was even less sure of her own identity and dealt chiefly with life by being active in social organizations. The patient was seen as being an extremely polite adolescent who was always consciously trying to say and appear to be doing the right things at the right time. She was treated vigorously by the medical staff and the gastroenterologist with corticosteroids, antispasmodics, and additionally with tranquilizers suggested by the psychiatric consultants. A team approach was established, with each member having clear responsibility for a specific area of treatment. Meetings were held frequently so that communication could be maintained. The addition of the patient to this team was both valuable and effective in giving the patient a sense of responsibility. Additionally, the parents were seen in therapy by a psychiatrist and a female social worker. Possibly the most valuable aspect of her treatment program was that of the availability of a young interested graduate nurse with whom this young female patient could identify and learn appropriate roles. The follow-up study revealed that this patient had left home and returned East to school where she was progressing nicely in social relationships, as well as in academic endeavor.

Supportive psychotherapy can provide effective treatment for the patient with ulcerative colitis and this includes diet, sedation, vitamins, drugs and blood, but chiefly a good relationship with a physician or team. We have utilized a form of anaclitic therapy as described by Margolin.[2] This is based on the principle that these patients need care, support and protection. We pay compliments on the dress and appearance of our women patients and on the diligence and meticulous work habits of our male patients. There is no attempt at insight into any of their personality

deficiencies during the acute phases of treatment. While obtaining a thorough anamnesis, we make the patient believe that his opinions and values are appreciated, and we adopt the attitude of a sympathetic listener. We may attempt to get the patient to act out hostilities, and find that these usually fail. We give support, therefore, by expressing indignation about the way a patient was treated by an aggressor, and offer to enter into this matter for him. This form of approach is called "transferential aggression." When social and marital difficulties emerge, we give aid by holding conferences and meetings; always ascertaining cooperation on the part of the significant others in these meetings. An attempt is made to structure appointments which are frequent, short, and have a definite time. Most of all, we avoid shying away from the patient's great dependence on the doctors and the nurses. We recognize that the illness promotes regression of an already immature dependent individual, and we do everything we can to promote this regression and to make the patient comfortable. In each session we show concern over the patient's physical condition. The first stage of this program is one of total permissiveness. This applies not only to the family, but also to the ward personnel and to the house staff. When the disease improves, the patient is safe and reality testing is good, gradual withdrawal from this program is instituted. Some interpretation of the meaning of the patient's wishes and needs may be made. Although demands are still met, the patient is made aware of them. Management of the second and third stage depends upon the individual conflicts, and further therapy should be worked out in an outpatient setting.

Summary

Traditional methods of consultation and management in ulcerative colitis are found to be ineffective. The establishment of a new approach for the total management of the patient is required. Critical decisions regarding the need for hospitalization can then be based on neither physical or emotional factors alone, but on intelligent assessment from day to day as to how the physical and emotional factors interact. The decision to hospitalize depends as much on the number of stools per day as it does upon the number of malignant environmental pressures which are too overwhelming to be dealt with on an outpatient basis. The extent to which visits from family members are allowed should depend upon physical tolerance plus the degree to which contact with certain significant persons affects the person's illness. When the physician is writing an order for bed rest he must weigh the level of hemoglobin against the possible adverse affect that rest might have on a patient who wishes to give up and withdraw from everything. It is not by referring to consultation forms in the chart that these determinations can best be made, but rather through the day-to-day awareness of each factor so that the physician, psychiatrist and surgeon can arrive at the best formula for handling a particular patient.

References

1. Murray, C. D.: Psychogenic Factors in Etiology of Ulcerative Colitis and Bloody Diarrhea, Am. J. M. Sc. 180:239-248 (Aug.) 1930.
2. Margolin, S.: Psychotherapeutic Principles in Psychosomatic Practice, In Recent Developments in Psychosomatic Practice, Lippincott, pp. 134-153, 1954.
3. Bowlby, J.: Childhood Mourning and Its Implications for Psychiatry, Am. J. Psychiat. 118:481-498 (Dec.) 1961.
4. Engel, G. L.: Is Grief a Disease? A Challenge for Medical Research, Psychosom. Med. 23:18-22 (Jan.-Feb.) 1961.
5. Adamson, J. D., and Schmale, A. H., Jr.: Object Loss, Giving Up, and the Onset of Psychiatric Disease, Psychosom. Med. 27:557-576 (Nov.-Dec.) 1965.
6. Schmale, A. H., Jr.: Relationship of Separation and Depression to Disease, Psychosom. Med. 20:259, 1958.
7. Kollar, E., Fullerton, D., Di Censo, R., and Agler C.: Stress Specificity in Ulcerative Colitis, Compr. Psychiat. 5:101-112 (Apr.) 1964.
8. Waggoner, R.: Depression the Simulator, Psychosomatics 2:264, 1961.
9. Hoogerbeets, J. D., and Marder, L.: Psychodynamics and Physiological Correlates of Psychosomatic Illness, Presented at Int. Congr. Academy of Psychosomatic Medicine, Majorca Spain, Sept. 1966.
10. Groen, J., and van der Valk, J. M.: Psychosomatic Aspects of Ulcerative Colitis, Practitioner 177:577-584 (Nov.) 1956.
11. Engel, G. L.: Studies of Ulcerative Colitis: Clinical Data Bearing on Nature of Somatic Process, Psychosom. Med. 16:496-501 (Nov.-Dec.) 1954.
12. Engel, G. L.: Studies of Ulcerative Colitis: Nature of Somatic Processes and Adequacy of Psychomatic Hypothesis, Am. J. Med. 16:416-433 (Mar.) 1954.
13. Engel, G. L.: Studies of Ulcerative Colitis: Nature of Psychologic Processes, Am. J. Med. 19:231-256 (Aug.) 1955.
14. Engel, G. L.: Studies of Ulcerative Colitis: Significance of Headaches, Psychosom. Med. 18:334-346 (July-Aug.) 1956.
15. Engel, G. L.: Studies of Ulcerative Colitis, Am. J. Dig. Dis. 3:315, 1958.
16. O'Connor, J. F., Daniels, G., Karush, A., Flood, C., and Stern, L. O.: Prognostic Implications of Psychiatric Diagnosis in Ulcerative Colitis, Psychosom. Med. 28:375, 1966.
17. Jackson, D. D., and Yalom, I.: Family Research on the Problem of Ulcerative Colitis, Arch. Gen. Psych. 15:410, 1966.
18. McDermott, J. F., Jr., and Finch, S. M.: Ulcerative Colitis: Physician Teamwork in the Treatment, Clin. Pediat. 3:75-82 (Feb.) 1964.

▶ Dr. Marder, University of Southern California School of Medicine, Los Angeles, Calif. 90033.

Treatment of Serious Infections Due to Common Bacteria

N. JOEL EHRENKRANZ, M.D.; JOSEPH R. JANNACH, M.D., and PETER D. McMICHAEL JR., M.D.

Among the commensal aerobic bacteria of man, Escherichia, Aerobacter-Klebsiella, Proteus, Pseudomonas, staphylococci and streptococci not only colonize the skin or mucous membranes as resident microflora but also, at times, invade tissues and cause life-threatening infection. The occurrence of a major infection with such organisms often indicates some impairment of host defenses—anatomic or physiologic—and treatment requires considerable knowledge and skill. As a background to the management of these clinical problems, this report presents some factors concerned with dissemination of commensal bacteria and patterns of antibiotic sensitivities seen at Jackson Memorial Hospital between 1959 and 1965. Therapeutic practices of the infectious disease division of the University of Miami School of Medicine with reference to use of newer antibiotics are reviewed.

Epidemiology in the Hospital

The occurrence of bacteremia in persons with these organisms is shown in table 1. As can be seen from the percentage distribution over the five years sampled, there has been relatively little change in the incidence of Staphylococcus aureus* bacteremia over this period. The view that staphylococcal infections are no longer a problem is not borne out by any major decrease in the yearly incidence of Staph. aureus bacteremia.

Dr. Ehrenkranz is chief of the Infectious Diseases Division and Professor of Medicine; Dr. Jannach is clinical pathologist and Associate Professor of Pathology, and Dr. McMichael is a former resident in infectious diseases, all of the University of Miami School of Medicine and Jackson Memorial Hospital, Miami.

*In this paper Staph. aureus refers only to coagulase-positive staphylococci.

The mean monthly incidences of Staph. aureus and Escherichia coli bacteremia for 1959-1965 are shown in figure 1. The frequency of E. coli bacteremia was fairly constant throughout the year and ranged between 3.0 and 4.8 new patients per month. When analyzed (by a Poisson distribution) in relation to the number of hospitalized patients discharged per month, E. coli bacteremia appeared to reflect a small fixed portion of that population, genitourinary or gastrointestinal infections undoubtedly being the source in most. By contrast, the monthly occurrence of Staph. aureus bacteremia varied a great deal. In February, March, July, August and October the incidence was 6.2 to 7.6; in November, December, April and May it fell to 3.8 to 4.8. When Staph. aureus bacteremia was related to the monthly discharge rate of hospitalized patients, these monthly variations in bacteremia each year correlated directly with the changes in the number of hospitalized patients ($P = 0.005$). To a lesser extent there was also a correlation of Staph. aureus monthly bacteremia with the monthly number of deaths in the hospital. The association of Staph. aureus bacteremia and hospital population may be explained by more person-to-person spread of Staph. aureus when there is an increase in the patient population. The lack of such an association for E. coli bacteremia is undoubtedly due to a different route of infection. Staphylococci characteristically infect through the skin or respiratory mucosa, whereas E. coli invades primarily from the gut or genitourinary areas. In relation to the environment of a hospital alone, shifts in staphy-

Table 1.—Bacteremia Due to Commensal Microorganisms in Patients at Jackson Memorial Hospital 1959-1965

Year	Number of Patients	Per Cent Distribution of Infecting Bacteria					
		Staph. aureus	E. Coli*	Aerobacter**	Pseudomonas	Proteus	Others***
1959	193	26.4	20.7	17.6	17.0	10.8	7.1
1960	260	31.6	23.0	8.6	10.5	15.4	9.6
1963	250	35.6	18.0	12.8	8.4	10.8	8.8
1964	211	23.6	23.6	16.5	5.2	12.7	15.5
1965	220	25.0	20.9	15.9	10.9	8.6	13.5

*including all strains of Escherichia
**including Klebsiella
***including Alcaligenes, Mimeae, etc.

lococcal colonization on the skin or respiratory mucosa are more apt to occur than are changes in Escherichia in the gut or pelvic flora.

Treatment of Gram-Positive Coccal Infections

Strains of Staph. aureus, penicillinase-producers or not, with but very rare exceptions are sensitive to one of the following penicillinase-resistant penicillins: methicillin (Dimocillin, Staphcillin), oxacillin (Prostaphlin, Ristopen), nafcillin (Unipen), cloxacillin* (Tegopen), and to-be-released dicloxacillin. Methicillin is administered only parenterally since it is unstable in acid, in contrast to the others which are acid-stable and can be given orally or parenterally. The main therapeutic action of methicillin is against penicillinase-producing Staph. aureus; the others, classified as isoxazolyl penicillins, are effective against a variety of gram-positive bacteria. Methicillin, while still in current usage, is thus likely to be superseded. Although differences in blood levels occur after oral administration of the various isoxazolyl penicillins, these differences do not reflect the outcome of treatment, particularly when parenteral routes are used. A physician need familiarize himself with just one of this group. Ampicillin (Polycillin, Penbritin, Omnipen) has no place in the treatment of staphylococcal infections. It is totally ineffective against penicillinase-producing strains and is much more costly but no more effective than penicillin G for penicillin sensitive strains.

For patients who are not allergic to penicillin, life-threatening staphylococcal infections such as bacteremia, osteomyelitis, endocarditis, pneumonia, renal carbuncle, brain or other parenchymatous abscesses should be treated parenterally with an isoxazolyl penicillin. Intravenous therapy may be started first, but as soon as possible the route should be changed to the intramuscular administration to avoid cutdowns or "intracaths" and the serious problems of superinfection that they engender.[1] In both children and adults, treatment is begun with 0.5 to 1.0 Gm. every four hours (50 to 100 mg. per kg. per day). This large dose can be decreased after several days if there is a good clinical response. After several weeks, treatment may be changed to the oral route in patients in whom prolonged treatment is necessary. Whereas some strains of Staph. aureus are not penicillinase producers, or produce penicillinase in such low quantities that huge doses of penicillin

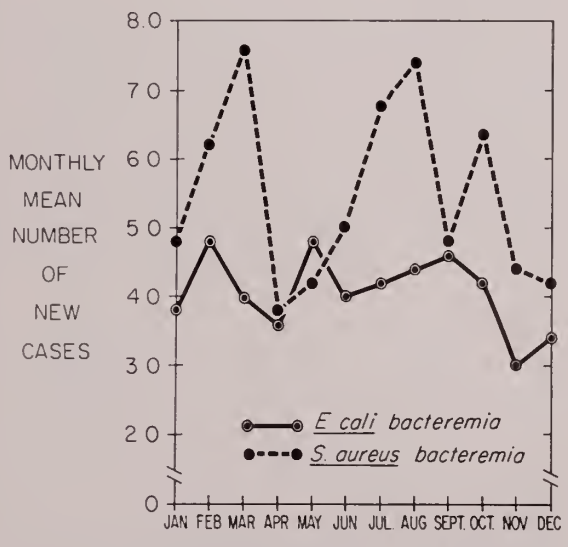


Fig. 1.—The monthly distribution of new cases of S. aureus and E. coli bacteremia at Jackson Memorial Hospital 1959-1965.

*Available at present for oral use only.

G could be effective, penicillin G should not be used at the outset until the penicillinase-producing ability of the infecting staphylococcus is determined. If the organism is sensitive to penicillin G one may change to penicillin G in dosage of 6 to 20 million units a day. Such treatment will necessitate intravenous administration; for this, scalp-vein needles are advised. The side effects of the several isoxazolyl penicillins are similar, namely drug fever, drug eruption and eosinophilia.

A patient who is allergic to one penicillin should be considered to be allergic to all, since the 6-amino-penicillinic acid nucleus is allergenic and is common to all penicillins. The use of corticosteroids to suppress the penicillin reaction and permit continuation of the penicillin has been described.[2] We believe such a practice is potentially dangerous since serious reaction to penicillin can occur despite the administration of the corticosteroids, and the host's ability to deal with infection is markedly limited by the prolonged use of corticosteroids. Cephalothin (Keflin) in dosage of 2 Gm. every two hours intravenously, to-be-released cephaloridin (Keflordin) in dosage of 1 Gm. every six hours intramuscularly, vancomycin (Vancocin) 1 Gm. every 12 hours intravenously or bacitracin 20,000 units intramuscularly every six hours, may be administered to adults who are allergic to penicillin. Appropriately smaller doses are given to children. These antibiotics are effective against almost all strains. They are potentially nephrotoxic, however, and renal function must be carefully monitored on a daily basis during their administration.

We have seen allergic reactions to cephalothin in persons with prior penicillin reactions of the anaphylactoid type, urticaria or angioneurotic, or angiitis.[3] In some of these individuals, allergic reaction to a variety of other unrelated drugs also occurred. The cephalothin reactions we have observed in persons allergic to penicillin were not as severe as the penicillin reactions in these same patients.

Lincomycin,[4] erythromycin and oleandomycin lack the bactericidal effect upon staphylococcal cell wall synthesis that the penicillin group possess. We do not regard the former antibiotics as first line drugs for the initial treatment of serious staphylococcal infections; they certainly can be used in patients who are allergic to penicillin in situations where bactericidal antibiotic treatment is not necessary.

In general, the same therapeutic considerations obtain for bacteremia due to Staph. albus as for Staph. aureus; however, resistance to the newer penicillins may be somewhat more frequent with Staph. albus.[5] For treatment of infections with staphylococci resistant to the isoxazolyl penicillins and cephalosporins, vancomycin or bacitracin is suggested in dosage as previously outlined.

What results may be expected in treatment of Staph. aureus bacteremia? Since the terms "debilitation," "serious metabolic disorder" and "advanced age" are often used to indicate the likelihood of a poor therapeutic response, we have tried to quantitate these terms for prognostic purposes. After analysis of our earlier data we arrived at a classification scheme of risk and carried out a prospective study of efficacy of treatment in fair risk and poor risk patients. All but one subject had two or more blood cultures yielding Staph. aureus. Criteria for fair risk were: (1) lack of debilitation—a serum protein level of 1.8 mg.% or greater by serum electrophoresis, (2) lack of serious metabolic disorder—a blood urea nitrogen of 34 mg.% or less and (3) less than advanced age—18 through 65 years. Among such patients treated with a variety of antibiotics as described, 12 of 16 were cured (75%). Three of the four patients who died had undrained abscesses. By contrast 11 of 13 poor risk patients treated similarly died. These were persons whose serum albumen levels were lower or BUN levels were higher than the fair risk group or who were 66 years or older. Thus, in fair risk patients as defined here, good medical treatment along with drainage of abscesses where necessary can be expected to bring about good results.

Streptococcal antibiotic-sensitivities at the Jackson Memorial Hospital may be considered to be the same as in previous reports.[6,7] Penicillins and cephalosporins, lincomycin and erythromycin are virtually 100% effective for group A strains. Sulfonamides are effective prophylactically but not therapeutically.[8] Penicillin G is still the treatment of choice. The use of other antibiotics along with penicillin G in dosage of 12 to 20 million units for treatment of enterococcal endocarditis should be determined by special study.[9] It is worth while reemphasizing that tetracyclines are of relatively little value in streptococcal infections, since 20% of streptococci are resistant.[6,7]

Treatment of Gram-Negative Bacillary Infection

As can be seen from table 2, there have been no major shifts in disk sensitivities between 1961 and 1965 among gram-negative rods tested to colistin (Coly-mycin), chloramphenicol (Chloromycetin), kanamycin (Kantrex) or polymyxin B. For E. coli, kanamycin, polymyxin B, colistin and chloramphenicol are all very effective. For Proteus strains, kanamycin and chloramphenicol work well. At Jackson Memorial Hospital these antibiotics appear to be considerably less effective than polymyxin B or colistin for the Aerobacter-Klebsiella organisms. For the Pseudomonas group, polymyxin B or colistin and gentamicin (Garamycin) are the only antibiotics of value, and gentamicin is not commercially available for parenteral use.

Table 2.—Per Cent of Commensal Gram-Negative Bacteria, Sensitive to Chloramphenicol, Kanamycin and Polymyxin B and E* 1961 to 1965

	1961	1962	1964	1965
Escherichia				
Chloramphenicol	86	95	93	93
Kanamycin	90	96	92	97
Polymyxins	98	97	100	100
Aerobacter-Klebsiella				
Chloramphenicol	66	82	90	68
Kanamycin	77	81	87	74
Polymyxins	98	92	100	100
Proteus				
Chloramphenicol	82	82	85	90
Kanamycin	97	95	92	96
Polymyxins	2	1	1	1
Pseudomonas				
Chloramphenicol	28	20	25	30
Kanamycin	10	16	17	11
Polymyxins	91	93	98	99

*Sensitive to chloramphenicol 5 μcgm. disk, kanamycin 5 μcgm. disk, polymyxin, B 50 μcgm. disk, polymyxin E (colistin) 2 μcgm. disk.

Infections with gram-negative organisms are life-threatening if bacteremia is occurring and a variety of treatment programs is in use for their management. The mortality is high, particularly if hypotension is present and prompt treatment is necessary to be effective. This implies some measure of bacteriologic diagnosis at the bedside. Until the type and source of gram-negative infection are defined, we favor polymyxin B in dosage of 100 mg. intravenously every 12 hours for three doses along with chloramphenicol intravenously or intramuscularly in dosage of 250 mg. every three to four hours, for initial usage in an adult. This combination will deal with almost all of the enteric gram-negative bacilli. Within a day and a half of the start of this treatment the organisms causing the infection should have been identified and the patient's renal function status defined. At this time, if the infecting bacteria are Aerobacter or Pseudomonas, therapy can be changed to colistin intramuscularly in dosage of 75 to 100 mg. every 12 hours (2.5 to 3 mg. per kg.). If the infecting organisms are Escherichia, kanamycin is administered in dosage of 250 mg. every six hours intramuscularly or colistin as previously mentioned. For Proteus, kanamycin is usually the treatment of choice.

Some physicians advocate the use of kanamycin along with polymyxin B or colistin in overwhelming infections. We have the distinct clinical impression that in the adult this combination is more nephrotoxic than each drug singly, particularly in the elderly adult in whom such infections are common, and therefore does not aid in saving lives. If kanamycin-sensitive organisms are suspected, we believe treatment with this drug alone is indicated. We see no need for a loading dose of kanamycin, nor a dose that exceeds 1 Gm. a day (15 mg. per kg.). The renal function of patients with serious gram-negative infections is apt to be compromised and larger doses may be toxic in patients with diminished renal function. Polymyxin B and chloramphenicol together or kanamycin, as previously outlined, can be used for the first day even if the patient is oliguric or anuric. Thereafter, less drug is administered. Renal dysfunction requires a decrease in the dose of polymyxin B, colistin or kanamycin—all renally excreted antibiotics. A safe rule of thumb for continuing these antibiotics in a person with severe azotemia or oliguria is to administer one-half the usual daily dose every other day until the courses of infection and renal dysfunction are determined. Chloramphenicol dosage is not decreased in the presence of renal dysfunction since this drug is inactivated in the liver.

Chloramphenicol is apt to be more toxic than kanamycin in the newborn and the dosage of chloramphenicol should be limited to 25 mg. per kg. or less in such patients, if used at all. The dosage in the adult generally should not exceed 2 Gm. per day. Blood levels of chloramphenicol can be determined by gas chromatography[10] and this is a useful guide to therapy. Kanamycin appears to be tolerated better by the child than the adult, and can be used more freely.

Table 3.—Cost of Antibiotics for Parenteral Use*

	Single Dose	Cost	Adult Daily Dose	Cost
Oxacillin	500 mg.	$3.30	6 Gm.	$39.60
Nafcillin	500 mg.	3.38	6 Gm.	40.56
Cephalothin	1,000 mg.	4.78	6 Gm.	26.68
Kanamycin	250 mg.	4.00	1 Gm.	16.00
Colistin	150 mg.	10.00	300 mg.	20.00
Polymyxin B	150 mg.	8.70	300 mg.	17.40
Chloramphenicol	500 mg.	2.45	1.5 Gm.	14.70
Lincomycin	600 mg.	2.00	1.8 Gm.	6.00
Erythromycin	500 mg.	2.36	2 Gm.	4.72
Penicillin G	1,000,000 units	.20	12,000,000 units	2.40
Oleandomycin	500 mg.	2.39	2 Gm.	4.70

*Information kindly provided by Mr. Howell Glass of Jackson Memorial Hospital Pharmacy.

It may be argued that the polymyxins (Polymyxin B, colistin = polymyxin E), because of their large molecular size, do not penetrate tissues as well as smaller antibiotics. For example, the most effective treatment of pseudomonas meningitis is intrathecal rather than parenteral polymyxin.[11] The initial therapeutic goal, however, of treatment of serious gram-negative infection is to prevent bacteremia and disaster by administering drugs which will contain the infection in its local site. The polymyxins are eminently effective in this regard. Since gram-negative infections often develop secondary to anatomic dysfunction in the genitourinary or gastrointestinal tract which antibiotics cannot correct, the aim of antibiotic therapy is to limit spread of the infection and reverse its course; cure may be achieved by definitive correction of underlying abnormalities.

As far as the management of "gram-negative shock" is concerned, the reader is referred to recent publications dealing with this subject.[12] Correcting fluid and electrolyte disorders, acidosis and poor cardiac output are vital steps in reversing the shock along with selection of appropriate antibiotics.

Do ampicillin or the cephalosporins have any place in the management of the commensal gram-negative bacterial infections? The limited activity of ampicillin against commensal gram-negative bacteria, mainly E. coli and Proteus mirabilis, and the fact that ampicillin-resistant enteric bacteria have already appeared,[13] indicate that there is little justification for the initial use of this drug in treatment of these infections. Cephalosporins have a wider spectrum against commensal gram-negative bacteria than does ampicillin, but clearly not as broad as the polymyxins or kanamycin. The cephalosporins are less toxic than the latter antibiotics. The place of cephalosporins in gram-negative infection is a subject for more study.

Drug Costs

The cost of these drugs should be appreciated by all who administer them. The unit drug cost and the cost of a day's course administered parenterally is indicated in table 3.

Antibiotic Sensitivity Testing

Although results of antibiotic sensitivity testing can be lifesaving in guiding the correct therapy, reliance on this procedure without an understanding of its limitations will lead to errors in treatment. The physician should be sufficiently aware of technical pitfalls to inquire about them when procedural errors are suspect. Bacteriologic purity of the species to be tested is essential to obtain meaningful results. Testing of mixed cultures obtained directly from the clinical sources, or accidentally mixed in the laboratory, makes interpretation impossible because of possible interactions between organisms and differences in their response to the antibiotics. The number of organisms spread per unit area is also critical and probably the most common cause of inaccurate reports.[14] An inoculum that is too dense often gives results indicating false resistance, and one that is too light shows undue susceptibility. The commercial availability of paper disks containing antibiotics has helped standardize testing;[15] antibiotic disks that are outdated or inactivated as a result of improper storage often give incorrect results. Ideally, an internal control measuring the

response of known organisms to the various test disks should be employed each day. Unfortunately, this is rarely practiced. The media and its preparation have also been shown to influence results along with the incubation time, diffusion rates of the antibiotics, moisture, pH, and CO_2 concentrations during incubation.[16,17] Sulfonamide sensitivity cannot be determined in a medium containing p-aminobenzoic acid.

In addition to considering technical aspects of antibiotic testing, the physician must evaluate the appropriateness of the laboratory model. Several concentrations of drug are generally employed in tests to approximate in vivo conditions. At times the actual concentration of the antibiotic at the site of the infection may greatly exceed this estimate. For example, the urine concentrations of soluble sulfonamides and some antibiotics are often many times greater than that in the disks; this should be considered when bacteriuria is being treated. In other instances the special conditions of the infection are not reproduced in vitro. The intracellular pathology of certain infectious disease processes makes correlation with in vitro testing almost impossible. Salmonella typhosa is sensitive to a variety of antibiotics in vitro, but infections respond only to antibiotics that affect the stationary phase bacteria, inside the cell.[18] Finally, spontaneous improvement may occur. Enteric shigellosis or salmonellosis will often clear without specific treatment.[19,20] This makes any antibiotic, no matter how inappropriate, appear to have been effective. Of course, misdiagnosis of pulmonary infarcts for pneumonia or lack of appreciation of drug fever will invariably confuse the problem of antibiotic efficacy. Good bacteriologic procedures in clinical laboratories are important assets, but they are only a part of management of infectious disease cases.

We are grateful to Dr. M. Eugene Flipse and Dr. Richard C. Dever for their review of the manuscript during its preparation.

References

1. Moran, J. M.; Atwood, R. P., and Rowe, M. I.: A Clinical and Bacteriologic Study of Infections Associated With Venous Cutdowns, New England J. Med. 272:554-560 (Mar. 18) 1965.
2. Raper, A. J., and Kemp, V. E.: Use of Steroids in Penicillin-Sensitive Patients With Bacterial Endocarditis. A Report of Three Cases and Review of Literature, New England J. Med. 273:297-300 (Aug. 5) 1965.
3. Barrett, E. L., and Ehrenkranz, N. J.: Cephalothin Treatment of Patients With Life-threatening Bacterial Infections, Bull., Univ. Miami Sch. Med. 19:1-6, 1965.
4. Kagan, B. M.; Zolla, S.; Busser, R., and Liepnieks, S.: Sensitivity of Coccal and L Forms of Staphylococcus aureus to Five Antibiotics, J. Bact. 88:630-632 (Sept.) 1964.
5. Kjellander, J. O.; Klein, J. O., and Finland, M.: In Vitro Activity of Penicillins Against Staphylococcus Albus, Proc. Soc. Exper. Biol. Med. 113:1023-1031 (Aug.-Sept.) 1963.
6. Ehrenkranz, N. J.: Antibiotic Sensitivities of Common Pathogenic Bacteria of Patients at Jackson Memorial Hospital, Bull. Univ. Miami Sch. Med. 16:97-99 (Oct.-Dec.) 1962.
7. Ehrenkranz, N. J.: Antibiotic Sensitivities of Some Common Pathogenic Bacteria at the Jackson Memorial Hospital, Bull. Univ. Miami Sch. Med. 17:25-29 (Apr.-June) 1963.
8. LaBoccetta, A. C.; Rosenberg, M.; Harris, S., and Harris, T. N.: Scarlet Fever; Results of Controlled Study of 609 Patients Treated With Penicillin and Sulfisoxazole, Am. J. Med. 22:458-468 (Mar.) 1957.
9. Jawetz, E., and Sonne, M.: Penicillin-Streptomycin Treatment of Enterococcal Endocarditis: A Re-evaluation, New England J. Med. 274:710-714 (Mar. 31) 1966.
10. Resnick, G. L.; Corbin, D., and Sandberg, D. H.: Determination of Serum Chloramphenicol Utilizing Gas-liquid Chromatography and Electron Capture Spectrometry, Anal. Chem. 38:582-585 (Apr.) 1966.
11. Jawetz, Ernest: Polymyxin, Neomycin, Bacitracin; Antibiotics Monographs No. 5, New York, N. Y., M. Encycl, Inc., 1956.
12. Weinstein, L., and Klainer, A. S.: Management of Emergencies. IV. Septic Shock—Pathogenesis and Treatment, New England J. Med. 274:950-953 (Apr. 28) 1966.
13. Kabins, S. A., and Cohen, S.: Resistance-Transfer Factor in Enterobacteriaceae, New England J. Med. 275:248-252 (Aug. 4) 1966.
14. Barry, A. L.: The Routine Antibiotic Disc-Plate Sensitivity Tests, I. Variations in the Size of Inoculum, Am. J. M. Tech. 30:153-161 (May-June) 1964.
15. World Health Organization Technical Report Series No. 210: Standardization of Methods for Conducting Microbic Sensitivity Tests, World Health Organization, Geneva, 1961.
16. Barry, A. L.: The Routine Antibiotic Disc-Plate Sensitivity Tests. II. Technological Variations, Am. J. M. Tech. 30:333-342 (Sept.-Oct.) 1964.
17. Trainer, T. D.: The Effect of the Medium on the Results of Testing Sensitivity to Antibiotics, Tech. Bull. Reg. Med. Tech. 33:209-216 (Dec.) 1963; Am. J. Clin. Path., 41:101-108, 1964.
18. Hopps, H. E.; Smadel, J. E.; Bernheim, B. C.; Danauskas, J. X., and Jackson, E. B.: Effect of Antibiotics on Intracellular Salmonella Typhosa. II. Elimination of Infection by Prolonged Treatment, J. Immunol. 87:162-174 (Aug.) 1961.
19. Turk, D. C.: Shigellosis and Sulphonamides, Lancet, 2:460-461 (Aug. 27) 1960.
20. Dixon, J. M.: Effect of Antibiotic Treatment on Duration of Excretion of Salmonella Typhimurium by Children, Brit. Med. J. 5474:1343-1345 (Dec. 4) 1965.

▶ Dr. Ehrenkranz, 1700 N.W. 10th Avenue, Miami 33136.

The Spastic Esophagus

WILLIAM L. BAIRD JR., M.D.

Primary motor disorders of the esophagus in the past have been described under the terms "achalasia" and "cardiospasm." Motility studies of the esophagus have added another, described as diffuse spasm of the esophagus.[1] Palmer described cardiospasm as a persistent contraction of the cardial orifice, and achalasia as a neuromuscular disease of the esophagus with a loss of muscular tone.[2] These terms have been used synonymously. In the spastic esophagus there is increased pressure over a considerable length of the esophagus, thus differentiating this disorder from achalasia and cardiospasm.

The function of the esophagus can be impaired by collagen diseases, malignant disease and any condition causing an esophagitis.[3] In the spastic esophagus as a primary motor disorder, the reason for the spastic condition remains obscure. There is an absence of associated disease of the esophagus. Rider et al[1] indicated that the diagnosis is confirmed by roentgenologic examination revealing a significant increase in tertiary contractions. Under these criteria diffuse esophageal spasm has been considered a relatively rare disease. It may be possible that the cases which reveal the x-ray changes represent the more severe examples, and the disease is more common than believed. In gastroenterology, motor disturbances of the colon have been grouped in the irritable colon syndrome. X-ray evidence of spasm of the colon is not required to make this diagnosis. The experience gained in the presumptive diagnosis of the irritable colon has helped establish procedures of evaluation and methods of treatment.

The criteria for diagnosis of the spastic esophagus need to be established, and methods of treatment need to be evaluated. The syndrome clinically would include episodes of pain and dysphagia. Barium swallow would be necessary to exclude other diseases of the esophagus, but would not need to show spasm to confirm the diagnosis. Esophagoscopy and motility studies might be necessary at times to support the diagnosis. The methods of treatment have not been too well outlined. Nitroglycerin, local anesthetics, sympathomimetic amines and parasympathomimetic amines have been tried with varying degrees of success. In the more severe cases dilatation of the cardioesophageal junction with a pneumonic dilator and the Heller procedure have been used.[2] Recent experiences with this problem are presented.

Report of Cases

Case 1.—A 43 year old white man complained of an intermittent pain in the midsternal area of three years duration. This pain was not related to exertion. At times he had the sensation that swallowed material would seem to stick in the midsternal region. Liquids would be an offender as often as meat. Physical examination, barium swallow and electrocardiogram were normal. Esophagoscopy revealed no abnormalities. After the esophagoscopy the symptoms improved. The dysphagia returned at intervals of two to 12 months. Because of the improvement with esophagoscopy, the relapses were treated with a Hurst bougie. There was no indication of resistance to the bougie. He complained of a tight sensation in the chest for a few days after each procedure, but then the symptoms would subside.

Comment: Since there was no structural deformity, the reason for the improvement after esophagoscopy and bougienage remains obscure.

Case 2.—A 35 year old white woman awoke with a deep aching in the right breast which was aggravated by swallowing. It was not relieved by antacids. Physical examination and barium swallow were normal. She was given oxethazaine* but the aching became more constant. Esophagoscopy was normal and the symptoms subsided. No therapy has been needed in the past 14 months.

From the Department of Medicine, Manatee Memorial Hospital, Bradenton.

*Oxaine M (Wyeth Laboratories), a topical anesthetic.

Comment: This case demonstrates the therapeutic as well as diagnostic aspects of esophagoscopy.

Case 3.—A 53 year old white woman had a one year history of food sticking in the midsternal region. Meat seemed to be worse than other foods in causing difficulty. She had noticed that the symptoms were worse when she was nervous. Barium swallow was normal. A number 40 Hurst bougie was passed and she was given reassurance and a tranquilizer. In the next 10 months she had only one transient episode of esophageal spasm.

Comment: With the prior experience gained with esophagoscopy, this procedure was omitted and treatment proceeded directly with bougienage.

Case 4.—A 49 year old orange grove worker of Italian descent presented with soreness of the lower sternal region which also caused some aching in the face, midback and right arm. He described the symptoms as though he had swallowed a peach seed and the rough edges were hurting him on the inside and spreading out in all directions. He had had a similar episode one year earlier. Upper gastrointestinal series and gallbladder series at that time were normal. Physical examination, chest x-ray and electrocardiogram were normal. He was given oxethazaine and experienced immediate benefit. X-ray and esophagoscopy were scheduled, but he was not seen again. His wife was called and she said he was back in the orange grove, and that all his symptoms had disappeared.

Comment: This undoubtedly represents the spastic esophagus syndrome. The immediate response to the topical anesthetic confirmed the origin of the pain. It also demonstrated that at times a topical anesthetic will give a therapeutic response.

Case 5.—A 36 year old white man while on vacation was seized with a substernal discomfort which seemed like a pill caught in his throat. He could get relief at times by lying on his side, but lying on his back would aggravate the pain. The pain was so severe that he was hospitalized. Serial electrocardiograms were normal, and he was discharged to return home. He was instructed to see his doctor because he probably had "heart trouble." The pains were not related to exertion. He had a normal physical examination and laboratory studies including a "two-step" test. A barium swallow was normal. During the evaluation he appeared excessively apprehensive. A physician who was his neighbor had noted that he was becoming increasingly anxious over his business. Esophagoscopy was normal and he was started on oxethazaine. The symptoms improved but did not clear. He was then treated with a tranquilizer. After his anxiety improved all esophageal symptoms subsided.

Comment: This patient was initially considered to have cardiac pain. The role of anxiety in esophageal spasm is undetermined, but in this case appeared to be the predominant factor. The differentiation between esophageal and cardiac pain at times can be difficult. A careful history may demonstrate a relationship of the pain to swallowing rather than exertion.

Case 6.—A 70 year old white man had a two week history of a burning sensation aggravated by swallowing. His intake of food was limited and his weight was reduced from 138 to 127 pounds. X-ray revealed that no barium went beyond the upper sternal region. He was given oxethazaine, the symptoms improved, and a repeat barium swallow revealed curling and spasm of the esophagus. One radiologist was suspicious of a mass, but another radiologist thought that the x-rays were indicative of a spastic esophagus. He was discharged on oxethazaine and tranquilizers, and had outpatient bougienage with little success. A repeat x-ray in one month confirmed the mass. At operation he was found to have a carcinoma of the lung which had infiltrated the wall of the esophagus. He died several months later.

Comment: The diagnosis of a spastic esophagus is one of exclusion. The clinician must be alert to any variation in the clinical course or laboratory findings, and should not hesitate to repeat the diagnostic studies.

Summary

The spastic esophagus is a motility disorder without evidence of organic disease distinct from achalasia and cardiospasm. There is diffuse spasm of the esophagus which can be measured by pressure studies and can occasionally be demonstrated by barium swallow. The etiology is unknown. The patient presents with intermittent chest pain and dysphagia. There is no specific treatment. The first efforts of therapy should be to relieve anxiety and the use of a topical anesthetic agent. If this fails, esophagoscopy and intermittent bougienage may be helpful. If there is no response to these efforts, pneumonic dilatations or the Heller procedure may be indicated.

References

1. Rider, J. A.; Moeller, H. C., and Puletti, E. J.: Diffuse Esophageal Spasm, Am. J. Gastroent. 44:97-106 (Aug.) 1965.
2. Palmer, Eddy D.: Clinical Gastroenterology, New York, Hoeber and Row, 1963, pp. 24-25.
3. Saladin, T. A.; French, A. B.; Zarafonetis, C. J., and Pollard, H. M.: Esophageal Motor Abnormalities in Scleroderma and Related Diseases, Am. J. Digest. Dis. 11:522-535 (July) 1966.

Dr. Baird, Manatee Memorial Hospital, Bradenton 33505.

Congenital Unilateral Multicystic Kidney

Report of Two Cases Presenting As Abdominal Masses in Newborn Infants

WALTER L. SCHAFER, M.D.; FRANK V. FAZIO, M.D. and ROBERT E. SAMS, M.D.

Since Schwartz first described unilateral multicystic kidney disease in 1926, nearly 50 cases have been reported. Only seldom has this condition been discovered in the newborn; however, as symptoms which occur later such as vomiting and abdominal distention due to displacement of bowel by the mass, flank pain and pain in the renal area are absent in the newborn infant.[1,6]

We are presenting two cases of unilateral multicystic kidney disease presenting as palpable flank and abdominal masses in newborn infants.

Spence[11] classically described this lesion as consisting grossly of replacement of the entire kidney by an irregular mass consisting of many noncommunicating cysts held together like a bunch of grapes. No normal parenchyma can be found and the ureter is usually absent or hypoplastic. Microscopically the cysts are lined with a layer of cuboidal or flattened epithelial cells. Undifferentiated cells, primordial glomerular and tubular tissue and nests of cartilage may all be present as islets of solid tissue.

In contrast to polycystic kidney disease, no hereditary tendency has been reported in multicystic kidney disease.[5] It occurs equally in male and female. No predisposing factors such as rubella in pregnancy have been demonstrated. No associated anomalies have been reported.

Spence believed failure of union between the ureteral bud and metanephric blastema could be responsible for producing the lesion, a theory first proposed by Kampmeier.[9] Coppridge[6] also accepted this explanation and theorized that the absence of a true pelvis and the limited number of cysts present probably result from a defect at the 15 mm. embryo stage. The reason for this defect is unknown.

Abeshouse[1] and Arey[2] believed the multicystic kidney to be only an advanced form of cystic hypoplasia of the kidney. Abeshouse reported 18 cases of calcification of cysts in hypoplastic kidneys occurring in adults, and considered this to be the end stage of cystic degeneration.

Report of Cases

Case 1.—A full term female infant was delivered spontaneously April 30, 1966, following an uncomplicated labor. A mass in the left upper abdominal quadrant was discovered shortly after birth on routine physical examination. It was described as being freely movable, irregular, cystic and 6 cm. in diameter. Tentative diagnosis was that this represented a renal mass, though splenomegalia could not be ruled out. The remainder of the physical examination gave negative results.

Laboratory: Urinalysis revealed 1 leukocyte, rare erythrocytes, 8 to 10 squamous cells, few bacteria, no casts, pH 5, specific gravity 1.005; albumin, glucose and acetone were negative. A complete blood count revealed 4.32 million red cells, hemoglobin estimation 15, hematocrit level 45, 8,900 white blood cells with 4 band neutrophils, 40 segmented neutrophils, 1 eosinophil, 48 lymphocytes and 7 monocytes. Blood urea nitrogen was 12 mg.%.

X-Ray: A recumbent film of the abdomen revealed a large masslike density in the left upper quadrant and left midabdomen measuring approximately 8 by 4.5 cm. displacing the stomach medially and the intestinal loops to the right, suggestive of a large spleen or kidney. A chest film was interpreted as normal.

Intravenous pyelographic examination was performed after intravenous injection of 5 cc. of Conray 60. There

From the Department of Pediatrics, Mound Park Hospital, St. Petersburg.

was prompt but suboptimal function of the right kidney, and a moderately dilated collecting system of the right kidney was seen subsequently. The right ureter was dilated and tortuous, and pooling of contrast material was seen overlying the right side of the sacrum and the medial part of the right ileum, thought to represent a dilated tertuous right ureter. Delayed films were taken up to one and three hours. The three hour film showed the urinary bladder well filled and normal in size, shape and position.

No contrast material was seen on the left side at any time.

The outline of the right kidney, though poorly discernible appeared to be within normal range of size, shape and position.

The pooling of dye in the right lower segment of the abdomen was not definitely identified as being within the right distal ureter, and a differential diagnostic consideration included the possibility of a crossed ectopic left kidney with a dilated collecting system, and an enlarged spleen.

Cystoscopy: On May 6, 1966 cystoscopy and retro pubic pyelograms were performed. The urethra was calibrated through a number 16 French instrument without stricture. The number 14 infant cystoscope was introduced into the bladder. Clear urine was obtained. Inspection of the bladder revealed it to be normal in all respects. There were two ureteral orifices. A number 4 Whistle tip ureteral catheter was threaded up the right ureter. A retrograde pyelogram showed an essentially normal right kidney and ureter. The ureter was normal in course and caliber. Numerous attempts to pass various catheters into the left ureteral orifice more than 1 or 2 mm. were unsuccessful.

Surgery: On May 11, 1966 exploration was carried out through a subcostal incision made in the left upper quadrant. Thorough inspection of the abdominal contents revealed a normal right kidney. No pelvic kidney was encountered. A large retroperitoneal mass on the left side represented the mass which was palpable abdominally. The descending colon including the splenic flexure was pushed down and medial from this mass covered by a thin layer of mesentery. The adrenal gland was flattened on top of the mass but was spared as the mass was removed down to the renal pedicle. No ureter was encountered. The wound was closed in the routine manner.

Gross Pathology: The specimen consisted of a multicystic structure 6 by 6 by 4 cm. and weighed 95 Gm. The external surface was pale pinkish-gray and covered by a few tags of fat. Grossly the specimen did not resemble a kidney in that no solid tissue was discernible. The multiple cysts ranged up to 4 cm. in diameter although the majority of them were much smaller, measuring 1 cm. in diameter. All of the cysts were filled with clear straw-colored fluid. Their external surfaces were smooth and glistening as were their internal surfaces. The walls of these cysts were paper-thin throughout. Near the center of the specimen there was an ill-defined mass of relatively solid but dark reddish-brown hemorrhagic-appearing tissue which measured 1.5 cm. in the greatest diameter. The ureter and other hilar structures were not recognizable.

Microscopic Pathology: The sections consisted of connective tissue which was well vascularized and in which were numerous large and small cystlike spaces lined by flattened or low cuboidal epithelial-like cells. They were often surrounded by a thin layer of immature fetal type mesenchyma. Scattered throughout the supporting connective tissue were a few clusters of immature or disorganized renal tubules which were associated sometimes with rather widely scattered glomerulae as well as scattered, rather prominent, peripheral nerves and one microscopic piece of hyaline cartilage.

The postoperative course was uncomplicated and the patient was discharged on the eighth postoperative day.

Case 2.—A full term female infant was delivered spontaneously Nov. 18, 1965, following an uncomplicated labor. Shortly after birth a mass in the left upper quadrant of the abdomen was discovered on routine physical examination. The urologist thought the mass in the left flank was firm and posteriorly fixed. The remainder of the physical examination gave normal results. On the second postpartum day the infant was jaundiced and a serum bilirubin determination was 16.8. An anteroposterior supine film of the abdomen was negative.

Laboratory: Urinalysis revealed rare white cells, 10 to 15 erythrocytes, 20 to 30 epithelial cells, few bacteria, pH 5, specific gravity 1.005, and no albumin, glucose or acetone. A complete blood count showed the hemoglobin estimation to be 17.8 and white cells 13,400 with 12 band and 34 segmented neutrophils, 43 lymphocytes and 11 monocytes. The bilirubin did not exceed 16.8 (15.8 mg.% indirect and 1% direct). The BUN was 30 mg.%.

X-Ray: On preliminary films no mass density was discernible. The liver and spleen were normal in size. In spite of two subsequent injections of 6 cc. Conray 60 only very little dye was seen within the collecting system of the right kidney. There was no evidence of hydronephrosis on the right.

No function was seen on the left side. The bladder was normal in size, shape and position.

Barium enema examination of the colon gave negative results.

Surgery: On Nov. 25, 1965, the patient was transferred to another hospital. On November 29, a nephrectomy on the left side was performed. At this time a large multicystic left kidney was removed.

Gross Pathology: The specimen consisted of a markedly distorted organ which exhibited a multicystic appearance. It weighed 125 Gm. and measured 8 by 6 by 4 cm. The reniform shape was not retained and the organ was identified with much difficulty. The hilar structures were present toward one edge of the specimen. The cysts measured between 0.4 and 1.8 cm. in diameter and appeared filled with a clear fluid which was seemingly under tension. The cut surface of the specimen revealed no renal parenchyma proper, but total replacement by cysts lined by thin membrane.

Diagnosis: Multicystic Kidney.

Postoperatively the patient did well and has been followed for nearly 10 months without complications.

Discussion

Diagnosis of multicystic kidney in infancy and childhood is made on the basis of normal urinalysis, absence of function on excretory urogram with normal contralateral function, absence of hypertension, and occasionally absence of one half of the trigone or of one ureteral orifice in an infant with a palpable, lobulated, freely movable, nontender cystic mass in the abdomen.

The only accurate and safe diagnosis should be based on laboratory and excision biopsy as the differential diagnosis includes Wilms tumor and neuroblastoma as well as hydronephrosis, multilocular cystic kidney and true polycystic kidney.

In multilocular cystic kidney disease the lesion is unilateral but confined to one part of the kidney with normally functioning renal tissue present in the rest of the kidney. The cyst is multilocular and may communicate with the renal pelvis in

contrast to the multicystic kidney which lacks a pelvis.[7]

Multicystic kidney disease differs from polycystic disease in which the renal contour is maintained, and the cysts are of similar size. There is a strong hereditary tendency, associated anomalies are common and it is usually bilateral.

These apparent differences between polycystic and multicystic disease were disputed by Cimmino[5] who believed no real differentiation can be made between them on purely pathological grounds. He stated that cases of multicystic disease have not been followed long or carefully enough to determine whether a latent cystic process is present in the remaining kidney. The presence of utretic or hypoplastic ureter and various sized cysts with loss of renal contour, the main pathological criteria of multicystic kidney disease, also occur in the polycystic kidney. It will take many years to disprove this argument completely.

Treatment

The treatment of multicystic kidney disease when symptoms demand and the opposite kidney is found to be normal is nephrectomy. Under these circumstances the prognosis is favorable.

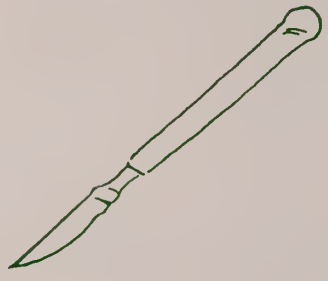
Summary

Unilateral multicystic kidney disease is a rare congenital condition characterized by replacement of normal renal parenchyma with multiple various-sized cysts. It is to be considered in the differential diagnosis of abdominal or flank mass in infants, and must be differentiated from polycystic and multilocular cystic kidney disease. Two cases of unilateral multicystic kidney disease in newborn infants are presented.

References

1. Aheshouse, B. S.: Congenital Renal Aplasia with Calcified Cystic Degeneration; Report of 2 Cases and Review of Literature, J. Internal. Coll. Surgeons 26:283-296 (Sept.) 1956.
2. Arey, J. B.: Cystic Lesions of the Kidney in Infants and Children, J. Pediat. 54:429-445 (Apr.) 1959.
3. Bricker, N. S.: Cystic Disease of Kidneys; Study of Dynamics and Chemical Composition of Cyst Fluid, Am. J. Med. 18:207-219 (Feb.) 1955.
4. Campbell, Meredith F.: Urology Vol. II, Philadelphia, W. B. Saunders, 1963, p. 1562.
5. Cimmino, C. V.: Congenital Unilateral Multicystic Disease of the Kidney, Am. J. Roentgenology, August, 1964, p. 281.
6. Coppridge, A. J., and Ratliff, R. K.: Unilateral Multicystic Kidney Disease, J. Pediat. 53:330-335 (Sept.) 1958.
7. Dainko, E. A.; Dammers, W. R., and Economou, S. G.: Multilocular Cysts of the Kidney in Children. Report of a Case and Review of the Literature, J. Pediat. 63:249-255 (Aug.) 1963.
8. Iuker, M., and Koesal S.: Loin Masses Due to Infant and Juvenile Unilateral Multicystic Kidney Disease, Arch. Surg. 81: 138; 798, 1960.
9. Kampmeier, O. F.: Hitherto Unrecognized Mode of Origin of Congenital Renal Cysts, Surg. Gynec. & Obst. 36:208-216 (Feb.) 1923.
10. Schwartz, J.: An Unusual Unilateral Multicystic Kidney in an Infant, J. Urol. 35:259-263, 1926.
11. Spence, H. M.: Congenital Unilateral Multicystic Kidney; Entity to be Distinguished from Polycystic Kidney Disease and Other Cystic Disorders, J. Urology 74:693-706 (Dec.) 1955.

Dr. Schafer, Mound Park Hospital, St. Petersburg 33701.



Postpartum Insertion of an Intrauterine Device

Preliminary Report

PETER A. McCRANIE, M.D. and DORIS N. CARSON, M.D.

The purpose of this paper is to present a preliminary report of the Birnberg Bow project—a contraceptive study. Covered by this report is the interval between Sept. 1, 1966 and Nov. 28, 1966. The project was conducted at Duval Medical Center, Jacksonville.

In the project, obstetrical patients underwent insertion of an intrauterine device (the Birnberg Bow) immediately following expulsion of the placenta; that is, while the patient was still on the delivery table. Reported herein are the short term results of such a procedure.

One may well ask why such a study was done at all, when it has already been repeatedly shown that insertion of an intrauterine device at the six weeks postpartum time approaches the ideal of an effective contraceptive that is relatively free of complications. The answer lies in the population served. One of the problems associated with a planned parenthood program for the indigent is that the postpartum patient may find herself pregnant before her six weeks check-up; or, even worse, she may not even return for her check-up. The Birnberg Bow project provides a means of contraception for this group of patients.

This project was supported by Planned Parenthood of Northeast Florida, Inc.

Method

All patients attending the Duval Medical Center Prenatal Clinic were, at their initial visit, offered the post-delivery Bow. Those showing interest were informed that the project was an experimental one, that the protection against pregnancy was not quite 100%, and that there was "a slight risk of infection or other complication." After having heard these negative statements, the patients were told that all evidence pointed to this being a safe procedure, and that they would be carefully observed while in the hospital. Forty-five patients accepted the Bow during the report period. During this same time, approximately 600 infants were delivered in the Obstetrical Unit.

The Birnberg Bow is a bow-shaped plastic intrauterine device measuring approximately 1½ inches by 1 inch. Immediately following delivery of the placenta, the obstetrician (usually an intern) "palms" the Bow in his regloved hand, and during manual exploration of the uterine cavity, simply leaves the device high in the cavity. Ordinary oxytocics are used. During the early days of the project, patients were kept in the hospital an extra two days to watch for signs of uterine infection; but when no increased incidence of endometritis was noted, the patients were, as is the hospital policy, discharged after 24 to 36 hours.

Results

Forty-five patients received the Birnberg Bow immediately following delivery. Of these, there were:

9 White

36 Negro

5 Primigravidas

18 Multiparas

22 Grandmultiparas (five or more children)

Endometritis in the immediate (within 72 hours) postpartum period occurred in only one patient. Two other patients with the Bow became febrile, but both demonstrated signs, symptoms and laboratory findings of urinary tract infection. Two patients had uterine bleeding, both at three weeks postpartum, requiring removal of the Bow.

For the purpose of this preliminary report, a six week follow-up was required of all patients. Of the 45 patients receiving the Bow, however, five have been lost to follow-up.

In this series, seven Bows were spontaneously expelled into the vagina. This expulsion usually occurred in the third postpartum week.

In one patient the clinical picture of acute pelvic inflammatory disease developed in the fourth postpartum week, and her physician removed the Bow. Another patient, at her six weeks visit, expressed an ill-defined resentment toward her Bow, and it was removed.

Discussion

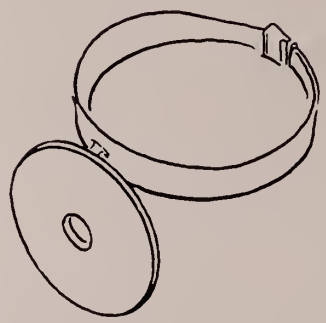
This series is too small to permit the drawing of any valid statistical conclusions. First impressions, however, indicate that insertion of an intrauterine device on the delivery table is not associated with an increased incidence of infection; most Bows will be retained by the uterus; bleeding is not a significant problem.

The Birnberg Bow project will be continued, and subsequent reports will deal with other aspects relevant to a contraceptive study.

Summary

Presented is a preliminary report of the Birnberg Bow project conducted at Duval Medical Center, Jacksonville. Initial impressions suggest that obstetrical insertion of an intrauterine device is a practical and effective means of contraception for the indigent.

▶ Dr. McCranie, 205 Marshall Taylor Doctors Building, Jacksonville 32207.



Night Leg Cramps . . . Unwelcome Bedfellow

In Diabetes[1], Arthritis[2], and Peripheral Vascular Disorders[2]



now . . . specific therapy for night leg cramps

Walker

QUINAMM™

Consistently effective, QUINAMM provided complete relief in 94% of 200 patients studied, many of whom were severe cases refractory to other medication.[3] Your prescription for one tablet at bedtime often controls painful night cramps with the initial dose . . . helps restore restful sleep.

THE NATIONAL DRUG COMPANY
DIVISION OF RICHARDSON MERRELL INC
PHILADELPHIA, PENNSYLVANIA 19144

Prescribing Informotion: Composition: Each white, beveled, campressed tablet cantains: Quinine Sulfate 260 mg. and Aminophylline 195 mg. **Controindication:** QUINAMM is contraindicated in pregnancy because of its quinine cantent. **Precoutions:** Aminaphylline may produce intestinol cramps in same instances, and quinine may praduce symptams af cinchonism, such as tinnitus, dizziness, and gastrointestinal disturbance. Discantinue use if ringing in the ears, deafness, skin rosh, ar visual disturbances accur. **Dosoge:** One tablet upan retiring. Where necessory, dasage may be increased ta ane tablet fallawing the evening meol and one tablet upan retiring. **Supplied:** Battles af 100 and 500 tablets. **References:** 1. Shuman, C.: Am. J. Med. Sci., 225:54, 1953. 2. Perchuk, E., et al.: Angiology, 12:102, 1961. 3. Rowls, W., et al.: Med. Times, 87:818, 1959. 6/67 Q-706A

even in ulcerative colitis...

characterized by:
— diarrhea, cramps, tenesmus
— bloody, mucoid, purulent stools



LOMOTIL® tablets/liquid

Each tablet and each 5 cc. of liquid contains:
diphenoxylate hydrochloride 2.5 mg.
(Warning: May be habit forming)
atropine sulfate 0.025 mg.

controls diarrhea

In six published studies[1-6] detailed results are given on the use of Lomotil in 111 patients with chronic ulcerative colitis. They show that Lomotil gave satisfactory to "excellent" control of diarrhea in more than two-thirds of these patients. As the disorder advances and destroys bowel musculature, the motility-lowering action of Lomotil, understandably, has less effect.

The successful use of Lomotil in a disorder as exceedingly difficult to treat as moderate ulcerative colitis emphasizes again its unsurpassed antidiarrheal effectiveness in these more common conditions:

- **Gastroenteritis**
- **Acute infections**
- **Spastic colon**
- **Drug induced diarrhea**
- **Functional hypermotility**

For correct therapeutic effect
Rx correct therapeutic dosage

Dosage: The recommended initial daily dosages, given in divided doses until diarrhea is controlled, are:

Children: Total Daily Dosage

3-6 mo. . . ½ tsp.*t.i.d. (3 mg.)
6-12 mo. . ½ tsp. q.i.d. (4 mg.)
1-2 yr. . . . ½ tsp. 5 times daily (5 mg.)
2-5 yr. . . . 1 tsp. t.i.d. (6 mg.)
5-8 yr. . . . 1 tsp. q.i.d. (8 mg.)
8-12 yr. . . 1 tsp. 5 times daily (10 mg.)
Adults: 2 tsp. 5 times daily (20 mg.) or 2 tablets q.i.d.

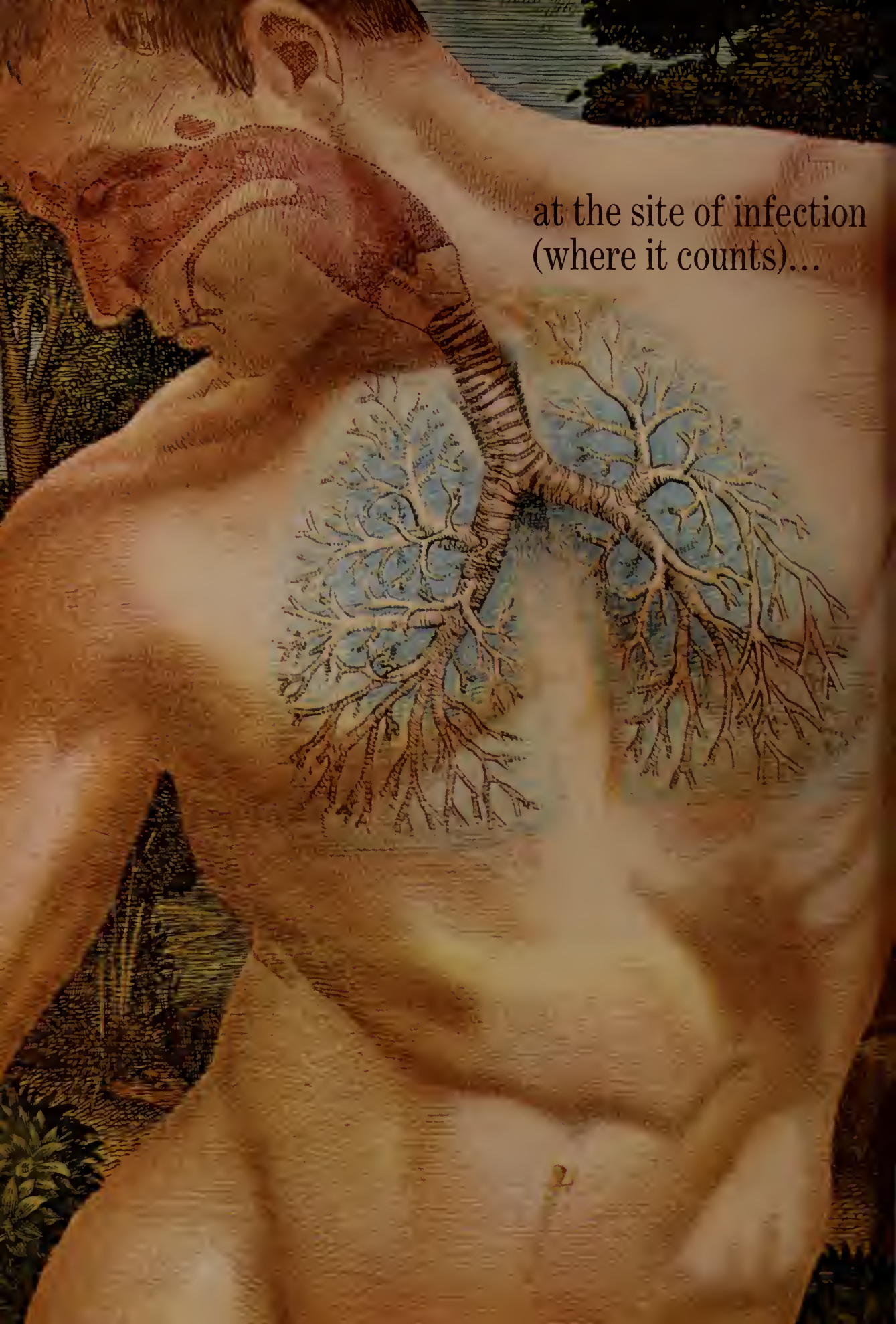
*Based on 4 cc. per teaspoonful.
Maintenance dosage may be as low as one-fourth the initial daily dosage.

Precautions: Lomotil is a federally exempt narcotic preparation of very low addictive potential. Recommended dosages should not be exceeded, and medication should be kept out of reach of children. Should accidental overdosage occur signs may include severe respiratory depression, flushing, lethargy or coma, hypotonic reflexes, nystagmus, pinpoint pupils and tachycardia. Lomotil should be used with caution in patients with impaired liver function or those taking addicting drugs or barbiturates.

Side Effects: Side effects are relatively uncommon but among those reported are gastrointestinal irritation, sedation, dizziness, cutaneous manifestations, restlessness, insomnia, numbness of the extremities, headache, blurring of vision, swelling of the gums, euphoria, depression and general malaise.

1. Barowsky, H., and Schwartz, S. A.: J.A.M.A. *180*:1058-1061 (June 23) 1962. 2. Cayer, D., and Sohmer, M. F.: N. Carolina Med. J. 22:600-604 (Dec.) 1961. 3. Hock, C. W.: J. Med. Ass. Georgia 50:485-488 (Oct.) 1961. 4. Van Derstappen, G., and Vandenbroucke, G.: Med. Klin. 56:962-964 (June 2) 1961. 5. Merlo, M., and Brown, C. H.: Amer. J. Gastroent. 34:625-630 (Dec.) 1960. 6. Weingarten, B.; Weiss, J., and Simon, M.: Amer. J. Gastroent. 35:628-633 (June) 1961.

SEARLE *Research in the Service of Medicine*


at the site of infection
(where it counts)...

Ilosone® provides more antibacterial activity than any other oral erythromycin

Acid stable, better absorbed... Ilosone produces faster, higher, more prolonged blood levels, even in the presence of food[1-3]

Because it is the most active form of oral erythromycin, Ilosone can help assure consistently greater antibacterial activity at the site of infection. Ilosone produces peak antibacterial blood levels two to four times those of other erythromycin preparations.[1,2] Not only are these levels attained earlier, but they are maintained for much longer periods. Even the presence of food does not seem to affect the activity of Ilosone.[1,3]

In the treatment of patients with bacterial infections susceptible to erythromycin, Ilosone has compiled an excellent therapeutic record. Since it exerts its greatest activity against gram-positive organisms, it is particularly useful in common respiratory and soft-tissue bacterial infections. Ilosone kills—not merely inhibits—streptococci, pneumococci, and more strains of staphylococci than any other macrolide antibiotic. This bactericidal action, coupled with the high antibacterial levels attained, makes Ilosone especially valuable in patients with low host resistance, such as infants, debilitated individuals, and diabetics.

Ilosone has shown no cross-resistance with penicillin and may be effective against organisms that have become resistant to that agent. Despite its high antibacterial activity, Ilosone has demonstrated a low incidence of side reactions. Blood dyscrasias, ototoxicity, and tooth staining have not been observed. Infrequent cases of drug idiosyncrasy, manifested by a cholestatic jaundice, have occurred, but there have been no known definite residual effects.

Now available:
New! Ready-mixed Ilosone Liquid 125! (Contains erythromycin estolate equivalent to 125 mg. erythromycin base per 5-cc. teaspoonful.)

700970

Ilosone®
Erythromycin Estolate

Lilly

(See next page for prescribing information.)

Ilosone®/the most active oral form of erythromycin

Description: Ilosone is the most active form of oral erythromycin that has been developed. Because it is stable in acid, well absorbed, and excreted in lesser amounts in the bile, it provides faster, higher, and longer-lasting levels of antibacterial activity (ABA) in the serum, even when taken with food, than do comparable doses of erythromycin.

Indications: Ilosone is indicated in infections caused by microorganisms sensitive to its action (especially staphylococci, hemolytic streptococci, and pneumococci). The drug is therefore useful in a high proportion of bacterial diseases encountered in clinical practice and particularly in the treatment of bacterial infections of the upper and lower respiratory tract and soft tissues.

In the treatment of acute bacterial pharyngitis and tonsillitis, this antibiotic has promptly eradicated the bacteria (streptococci) and has produced a parallel prompt clinical improvement. There have been no group A beta-hemolytic streptococci resistant to this preparation. In beta-hemolytic streptococcus infections, treatment should be maintained for ten days to prevent the development of rheumatic fever or glomerulonephritis.

Erythromycin estolate has proved to be very effective in pneumococcus pneumonia and in acute bronchitis with pneumococci on culture. Bronchopneumonia and otitis media in children have responded well to its use.

The antibiotic has been used very successfully in staphylococcus infections. Good therapeutic results have been obtained in soft-tissue infections, abscesses, cellulitis, carbuncles, wound infections, and furunculosis.

In serious staphylococcus infections, erythromycin preparations should be used only in combination therapy with other antimicrobial agents. As is the case with any treatment regimen used in these severe conditions, surgical procedures should be performed when indicated, and large dosages of the antimicrobial agents should be employed. In this fashion, Ilosone has been effective in staphylococcus pneumonia, osteomyelitis, septicemia, empyema, and meningitis.

Multiple 500-mg. doses of the drug have also been useful in gonorrhea and syphilis. Since penicillin is the drug of choice for the treatment of syphilis and gonorrhea, erythromycin estolate should be employed for these infections only in patients with a history of penicillin allergy. Also, other infections due to susceptible bacteria in patients known to be hypersensitive to penicillin or other antibiotics may be considered for treatment with Ilosone.

Contraindications: Ilosone is contraindicated in patients with a known history of sensitivity to this drug and in those with preexisting liver disease or dysfunction.

Adverse Reactions: Data obtained from seven years' use of propionyl erythromycin ester and erythromycin estolate (Ilosone) indicate that hepatic dysfunction with or without clinical jaundice may occur during or following courses of therapy with the drug.

Changes in liver function tests in such cases have been indicative of intrahepatic cholestasis. The symptoms appear to be the result of a form of sensitization. The initial symptoms have developed in some cases after a few days of treatment but generally have followed one or two weeks of continuous therapy or several courses of the drug. Symptoms reappear promptly, usually within forty-eight hours, if the drug is readministered to sensitive patients. Eosinophilia was noted in peripheral blood counts. The findings readily subsided without apparent residual effects when treatment was discontinued. Recovery was delayed in one reported instance. The physician indicated in this case that either drug-induced jaundice or viral hepatitis may have been responsible for the findings.

In one clinical study involving ninety-three patients treated with the antibiotic, three cases of jaundice were observed and an additional eleven cases developed some changes in liver function tests. Three of the patients had abnormal liver function tests a second time on readministration of the drug.

Even though it is assumed that not all cases of jaundice have been reported, it seems clear that the number is small compared with the amount of drug that has been used. Reported cases have included persons in whom there had been administered other drugs known to be associated at times with hepatic side-effects and cases in which the presence of viral hepatitis or other disease may have been responsible for the findings. In some of the cases, associated gastro-intestinal symptoms simulated the colic of biliary tract disease. In other instances, clinical symptoms and results of liver function tests resembled findings in extrahepatic obstructive jaundice. It appears that the occurrence of jaundice after administration of Ilosone is infrequent, but further investigations are being made to estimate its incidence more accurately.

In those cases mentioned above in which jaundice appeared to be definitely related to use of the drug, laboratory findings were characterized by increased direct-reacting bilirubin, elevated alkaline phosphatase levels, negative or weakly positive cephalin flocculation and thymol turbidity tests, elevated serum glutamic oxalacetic transaminase levels, peripheral eosinophilia, and normal cholecystograms.

Individual idiosyncrasy seems evident since jaundice has not been reported in other patients taking prolonged courses of the medication. Patients with chronic infection have been given 1 to 2 Gm. of the drug daily for periods of two to six months, and patients with rheumatic fever have taken prophylactic doses of 0.5 Gm. daily for two years without difficulty. In one group of 144 patients who received the drug daily for two years, no jaundice was noted. It was of interest that members of six of the patients' families, who were not taking the drug, had episodes of jaundice during the study period.

Transaminase and serum alkaline phosphatase levels were determined in a group of fifty-four adults and children who took 250 mg. of Ilosone daily for an average of sixteen months for rheumatic fever prophylaxis. The results were compared with those of a similar group of forty-four patients who received penicillin. There were no cases of jaundice in either group. Elevation of SGPT and serum alkaline phosphatase levels during the course of treatment was observed in one patient treated with Ilosone and in two patients treated with penicillin. Seven other patients in the group receiving Ilosone and four others in the penicillin group showed elevations in one of the tests at some time during administration of the drugs.

Very satisfactory therapeutic results, without toxicity, were reported in 102 pediatric patients who received short-term (ten day) courses of Ilosone in the treatment of streptococcus infections. Results of liver function tests in these patients were comparable to those in a similar control group who had received penicillin.

Gastro-intestinal disturbances not associated with hepatic effects are observed in a small proportion of individuals as a result of a local stimulating effect of the medication on the alimentary tract; however, the normal intestinal gram-negative bacterial flora is not appreciably altered by erythromycin drugs.

Although allergic manifestations are uncommon with the use of erythromycin, there have been occasional reports of urticaria, skin eruptions, and, on rare occasions, anaphylaxis.

Administration and Dosage: Ilosone is administered orally.

Ilosone Pulvules®, Ilosone Liquid 125, Ilosone, 125, for Oral Suspension, Ilosone Drops, Ilosone Chewable Tablets.

For infants and for children under twenty-five pounds of body weight, the usual dosage is 5 mg. per pound every six hours; for children twenty-five to fifty pounds, 125 mg. every six hours. (Tablets Ilosone Chewable should be chewed or crushed and swallowed with water.)

For adults and for children over fifty pounds, the usual dosage of Ilosone is 250 mg. every six hours.

For severe infections, these dosages may be doubled.

When larger doses are indicated, parenteral erythromycin therapy should be considered.

In the treatment of syphilis, the recommended total dosage is 20 to 30 Gm. given in divided doses for a period of ten to fifteen days. Close follow-up of the patient is necessary since erythromycin drugs have not had adequate evaluation in all stages of syphilis. Examinations of spinal fluid are recommended as part of the follow-up therapy.

For gonorrhea, 500 mg. four times a day for four days is recommended. In the treatment of gonorrhea, patients with suspected lesion of syphilis should have a dark-field examination before receiving antibiotics, and monthly serologic tests should be made for a period of three months.

How Supplied: Pulvules Ilosone, Capsules, N.F., 125 and 250 mg. (equivalent to base), in bottles of 24 and 100.

Ilosone Liquid 125, Oral Suspension, U.S.P., 125 mg. (equivalent to base) per 5-cc. teaspoonful, in 60-cc. and pint-size packages.

Ilosone, 125, for Oral Suspension, N.F., 125 mg. (equivalent to base) per 5-cc. teaspoonful, in 60 and 150-cc.-size packages.

Ilosone Drops, 5 mg. (equivalent to base) per drop, in 10-cc.-size packages, with dropper calibrated at 25 and 50 mg.

Tablets Ilosone Chewable, N.F., 125 mg. (equivalent to base) in bottles of 50. [0327

References: 1. Griffith, R. S., and Black, H. R.: Am. J. M. Sc., *247*:69, 1
2. Griffith, R. S., and Black, H. R.: Antibiotics & Chemother., *12*:398, 1
3. Hirsch, H. A., Pryles, C. V., and Finland, M.: Am. J. M. Sc., *239*:198, 1960.

Additional information available to physicians upon request.
Eli Lilly and Company, Indianapolis, Indiana 46206.

Lil

7K

DEPRESSION



NORPRAMIN®
(desipramine hydrochloride)

ANTIDEPRESSANT FOR RAPID IMPROVEMENT

At the recommended dosage level —initially, 150 mg. per day— gratifying remission of the signs and symptoms of depression typically begins in 2-5 days. Its specificity for depression, rapidity of action and usually mild side effects are significant reasons for prescribing NORPRAMIN (desipramine hydrochloride) in depression of any type . . . any degree of severity.

A few patients, sensitive to central nervous system stimulants may become restless as depression is lifted—in such cases dosage may be reduced or a tranquilizer added.

IN BRIEF:

INDICATIONS: In depression of any kind —neurotic and psychotic depressive reactions; manic-depressive or involutional psychotic reactions.

CONTRAINDICATIONS: Glaucoma, urethral or ureteral spasm, recent myocardial infarction, severe coronary heart disease, epilepsy. Should not be given within two weeks of treatment with a monoamine oxidase inhibitor.

RELATIVE CONTRAINDICATIONS: (1) Patients with a history of paroxysmal tachycardia. (2) Patients receiving concomitant therapy with thyroid, anticholinergics or sympathomimetics may experience potentiation of effects of these drugs. (3) Safety in pregnancy has not been established.

PRECAUTIONS: (1) Outpatient use of desipramine hydrochloride should not be substituted for hospitalization when risk of suicide or homicide is considered grave. (2) If serious adverse effects occur, reduce dosage or alter treatment. (3) In patients with manic-depressive illness a hypomanic state may be induced. (4) Discontinue drug as soon as possible prior to elective surgery.

ADVERSE EFFECTS: Side effects, usually mild, may include: dry mouth, constipation, dizziness, palpitation, delayed urination, "bad taste," sensory illusion, tinnitus, anxiety, agitation and stimulation, insomnia, sweating, drowsiness, headache, orthostatic hypotension, flushing, nausea, cramps, weakness, blurred vision and mydriasis, rash, tremor, allergy, agranulocytosis, altered liver function, ataxia, and extrapyramidal signs.

DOSAGE: Optimal results are obtained at a dosage of 50 mg., t.i.d. (150 mg./day). **SUPPLIED:** NORPRAMIN (desipramine hydrochloride) tablets of 25 mg.; bottles of 50, 500 and 1000; and tablets of 50 mg., in bottles of 30, 250 and 1000.

LAKESIDE

LAKESIDE LABORATORIES, INC., Milwaukee, Wisconsin 53201



'Don't Confuse Me With the Facts'

While attending the FMA conference of county medical society presidents and secretaries in Orlando in January, I found myself fascinated by the different ways in which people can look at the same issue. I tend to be a gullible listener and to be temporarily swayed by whatever cleverly expressed opinion I happen to have been exposed to most recently. It takes some time before the rest of the facts slowly infiltrate the recent speaker's honeyed phrases and some sort of perspective begins to form. I admire those people who seem to be able to see right through the content of a speech immediately—but I've also noticed that this is often because they subscribe to the motto "My mind's made up—don't confuse me with the facts."

These latter gentlemen were sprinkled fairly liberally about at Orlando, and they occasionally used their considerable experience to negate the presentations of others. They quoted from decisions of FMA and AMA like Joseph Smith reading from the Book. One speaker used the principle of "usual and customary fees for governmentally financed programs" to arouse opposition to the 20% good faith contingency deduction in our Hillsborough County Demonstration Project. Another reported on the "direct billing" policy in a happy series of percentages which showed that FMA doctors, by and large, are holding the line against those filthy assignments.

Now I think that both the principle of direct billing and that of customary fees, stated clearly at Hollywood last May, are essentially sound, but it distressed me to hear them repeated exclusively in terms of "what's best for the doctors," with never a mention of what's best for the patients. It could be that the doctors in New Hampshire, for example, where 80% of Medicare is handled by assignment, are really more concerned about their patients' financial welfare than we are—or perhaps in that largely rural state they just know their patients' financial limitations better. I sincerely think that we ought to consider our principles of action in terms of something besides our personal good.

If the federal government insists, as it does, that it will provide a large percentage of the cost of all indigent care by 1970, it is proper for FMA to resist the resulting governmental control by encouraging direct billing—but it is not right then to recommend that this principle be used to oppose a program such as the Hillsborough County Demonstration Project, which itself was designed by FMA to oppose that same federal control.

Similarly, if the members of FMA believe, as I believe, that there is no reason for doctors to be paid on a lesser scale than other vendors of care for the indigent, they are wholly right in saying so. But to oppose the voluntary underwriting of a doctor-controlled plan for indigent care by insisting on an unreasoning adherence to this principle is, I believe, self-defeating.

We are justified—indeed, we are obliged—to establish the principles under which we mean to approach the problems of governmental medicine, but we also ought to have the courage to modify, to amend or even to abolish principles previously established when sober judgment and our medical obligation require it.

Remember that there is a great gulf between determination and intransigence: *I* am a man of conviction; *YOU* are somewhat opinionated, but *HE* is an obstinate fool. Let us be men of conviction, but let us not proceed to the subsequent stages.

Collin Baker, M.D.
Tampa



"When I couldn't even smell corned beef and cabbage,
I decided it was time for you, Doc."

Maybe he doesn't know when he's well off. But you might want to prescribe long-acting Novahistine LP anyway.

Two tablets in the morning and two in the evening will usually provide day and night relief by helping to clear congested air passages for normal, free breathing. Novahistine LP is formulated to provide continuous therapeutic effect for 8 to 12 hours. The decongestant ingredients help restore normal mucus secretion and ciliary activity—physiologic defenses against infection of the respiratory tract.

Use cautiously in individuals with severe hypertension, diabetes mellitus, hyperthyroidism or urinary retention. Caution ambulatory patients that drowsiness may result.

Each Novahistine LP tablet contains: phenylephrine hydrochloride, 25 mg., and chlorpheniramine maleate, 4 mg.

NOVAHISTINE® LP

DOW **PITMAN-MOORE** Division of The Dow Chemical Company, Indianapolis



Special Article

Future Trends of Psychiatry

E. ARTHUR LARSON, M.D.

A brief paper such as this, on the broad and multifaceted topic "Future Trends of Psychiatry," is bound to be inaccurate, and also speculative. The opinions expressed are an admixture of my own, gained by directing a community-oriented college mental health service, some of my colleagues and those of the National Mental Health Program designers (AMA, APA, NIH). Part of the latter group is reflected in a recent report commissioned by the American Medical Association, the Millis Report.*

Before attempting to predict the future, I will briefly review the history of psychiatry as a medical specialty. This review is done for several reasons: Future programming in any field can only be adequately done with much respect for the past; psychiatry has always been a rather cloudy, and at times mystical, subject in the minds of lay people. This lack of clarity about psychiatry, however, also exists to a lesser degree in members of the medical profession and to some degree in the minds of psychiatrists. It must be remembered that in the essential respects as a specialty of the broad field of medicine, psychiatry is the youngest.

Presented to the professional staff of the Virginia Mason Clinic, Seattle, Wash., Jan. 13, 1967.

Dr. Larson is Assistant Professor of Psychiatry, University of Florida College of Medicine, Gainesville.

*The Graduate Education of Physicians: The Report of the Citizens Commission on Graduate Medical School Education, August 1966.

Review of Psychiatry

About 100 years ago a German psychiatrist named Kraepelin categorized his patients into alleged diagnostic groups. These categories were primarily based on symptomatic and prognostic similarities. The categories were then considered as "disease entities." The medical profession then followed suit by considering these actually artificial categories as factual illness entities. The years since Kraepelin have greatly reduced the number of "disease categories." It is the categorization as "disease" or "illnesses," however, that still shackles psychiatry. No other specialty of medicine classifies "entities" of symptomatic or prognostic similarity into "disease" or "illnesses" without the use of pathologic, biochemical or x-ray confirmation.

About 60 years ago, Sigmund Freud, a native of a prudish Viennese society, began clarifying these symptomatic and prognostic categories by adding two additional features: (1) A theoretical understanding behind the development of a symptom, and (2) A method of treatment that altered prognostic estimates. Freud was only beginning

his studies when he died. His death caused a temporary stalemate in the development of psychiatry as a specialty of medicine and what Freud considered incomplete, others considered the completed gospel.

Psychiatry began rapid growth as a specialty during World War II and during the postwar years. This growth is still being evidenced in multifaceted directions such as the growth of its theoretical bases, modifications to them, additions and increasing numbers of methods for reconceptualizing emotional dysfunction. A rapid growth of training programs is evidenced, from the initial impetus of the war needs to the continued national need for trained psychiatrists. Local, state and national programs, designed to increase the awareness of the general public to mental health problems, have met with success. As a consequence, there has been an increase in the numbers of persons seeking psychiatric help. Research has rapidly expanded in terms of evaluating theoretical concepts as well as the current highly significant research of a biochemical and neurophysiological nature. The classical psychoanalytic treatment model has been modified and remodified, with a resultant increase in the numbers of "basic," though differing, treatment techniques for the same types of "diagnostic entities."

Growth along so many facets has, in turn, caused national awareness of the current productivity of psychiatry as well as the awareness of national needs. Thus, currently, national financial backing is available for the latest "ideal treatment model," the Comprehensive Community Mental Health Center.

Such a rapid review does injustice to the hard work of many who have led to the development of psychiatry as a specialty over the past 100 years. Psychiatry, like medicine in general, has taken a rapidly accelerating pace. Psychiatry, however, unlike any other medical specialty, still rests only upon a theoretical and/or descriptive base; that is, there remains no definitive pathologic or biochemical diagnostic procedure to what we inaccurately call "psychiatric illness."*

*The Diagnostic and Statistical Manual of the American Psychiatric Association, revised 1952, refers to the "diagnostic categories" as "reactions." The general connotation, however, (lay, medical and psychiatric) remains that of "illness" or "disease."

Future of Psychiatry

A Drew Pearson type of prediction for the future, especially for the complex and multifaceted specialty of psychiatry, has many inherent dangers. The reader should recognize that what is to follow should be considered the guess of one psychiatrist. This guess should not be used as fact, but the reader is invited either to use it as a piece of information along with information from other sources in predicting the future or to disregard all predictions and to wait and participate in the future at some later date.

Internal Reorganization

Psychiatry will be reorganized internally as a specialty into two major service divisions and/or into two major types of psychiatrists. The first will be the more classically oriented psychotherapist using varying types of conceptual treatment models but still relying primarily on a one-to-one psychotherapeutic experience. The second type of psychiatrist will become an expert in the field of a comprehensive evaluation, and, from this frame of reference, an expert in prescribing with accuracy the ideal type of disposition for the particular problem confronting the patient and/or the family. Dispositions used will have a wide range of possibilities, only one of which being the mentioned expert in psychotherapy. This type of psychiatrist is now being trained and called the "community psychiatrist." Both types of psychiatrists will gradually relocate themselves until they are found primarily in general types of large clinics rather than in small isolated offices.

Education

A major task for psychiatry in the future will be education. The importance of the specialty as a healing art will not diminish; the importance of the psychiatrist as an educator will dramatically increase. He will become a key educator of the general public in terms of the concepts of mental health as opposed to the current status of the psychiatrist as the educator of the other physicians in the concepts of mental "illness." The Millis Report indicates that a portion of the training of the "primary physician" in the concepts of comprehensive medical care will be the job of the psychiatrist. (Other medical specialties to train the "primary physician" will include general medicine, pediatrics, medical gynecology and preventive medicine.) Other than the education of the gener-

al public and the education of the primary physician, there will, in the not too distant future, develop a new mental health profession for the purposes of this report called the mental health specialist. The mental health specialist will be analogous to psychiatry as the public health nurse is to general medicine. It is uncertain whether this mental health specialist will be a nurse, a social worker, former military psychiatric corpsman or an admixture of all three plus other persons particularly interested in mental health such as chaplains or school teachers. The need served by the mental health specialist will, in part, be within the Comprehensive Community Mental Health Centers as well as in even newer programs, not yet developed nationally, which will be along the lines of the public health preventive model.

Diagnostic Changes

Changes in "diagnostic" labels will occur. As the changes occur, they will again be revamped. The first major change will be a general acceptance of the Unitary Concept of mental "illness." This concept is well explained in Karl Menninger's book, "The Vital Balance." Essentially, it is the acceptance of current diagnostic labels for descriptive uses only, recognizing that there is only one variety of mental (emotional) dysfunction. This dysfunction does not vary from one person to the next pathologically but varies only in quantitative degrees and fluctuates in each of us with time and to varying degrees. Though the unitary concept will become accepted by psychiatry, it is also just as probable that it will be revamped and subdivided, dependent, however, on research. The current trends in biochemical as well as a neurophysiological research indicate that we will probably have three general categories of "mental illness": basic biochemical errors which cause secondary emotional dysfunction; basic emotional dysfunction which in turn causes biochemical rearrangements, and emotional dysfunction that is neither caused by biochemical fluctuations nor causes biochemical rearrangements and can be best described by the work of Harry Stack Sullivan as "living difficulties." This latter grouping will accurately fit the Unitary Concept.

Treatment

The future holds many new techniques in the treatment and/or therapy of emotional dysfunction. The current expanding research along biochemical and neurophysiological lines is likely to unlock many of the secrets of memory storage. Repression is central in many of the current conceptualizations for the development of symptoms of emotional dysfunction. Unlocking repression will thus be possible by the classical psychoanalytical approach as well as by some type of biochemical approach. (There are many other ramifications that may occur as a result of the unlocking of the neurophysiological secrets of memory storage.) Hospitalization techniques in the future will tend to demarcate themselves more clearly in the two general types. The first type of hospitalization will be short term, probably not longer than three or four weeks. This type of hospitalization will be readily available to all the public either on a private or on a community-financed base and will not be in units designed only for the "mentally ill," but within the general medical wards. Short term hospitalization will be useful for crisis intervention programs, certain types of evaluation procedures and short term intensive individual and family therapy. It will be useful to the "community psychiatrist" in effecting the most feasible type of disposition for a patient's difficulty. Short term hospitalization will not mean hospitalization of one person alone, but in many cases will probably mean the hospitalization of an entire family complex. The second type of hospitalization will be a long term treatment procedure, primarily located in state hospitals, with probable decreasing frequency in large private "psychiatric" hospitals. This latter type of hospitalization will find decreasing usefulness, though still useful for those patients not responding to the increasing variety of treatment techniques or in those situations where an appropriate disposition outside of the hospital setting cannot be developed.

Prevention

The combination of many of the stated future trends will direct the specialty into its most important impact on the general public, that being in the prevention of emotional dysfunction. This will be done by the increasing sharing with the general public of the already gained knowledge of the psychiatric profession. It will be done through the education of many nonpsychiatrists in the detection of developing emotional difficulties and the instituting of effective immediate treatment techniques of the resolution of the difficulty prior to the development of an "illness" (dysfunction).

Conclusion

From the history of psychiatry, its current involvements, its current research areas and its possible direction along the predicted line, it must be left up to the reader to fathom whether or not psychiatry in the future will still be one of the medical specialties. If it remains a medical specialty, and I believe that it should, in all probability its unique (nonpathologic) position shall remain, and the indicated primary biochemical illnesses will become the province of other specialties of medicine.

▶ Dr. Larson, University of Florida College of Medicine, Gainesville 32601.

YOUR Patronage Has Made Our Growth Possible

Medical Supply Company of Jacksonville



Home Office

JACKSONVILLE
4539 Beach Blvd.
Telephone FL 9-2191

ORLANDO
1511 Sligh Blvd.
Telephone GA 5-3537



Recognize this?
Chloresium® Ointment
—it's recognized for effectiveness in healing ulcers, soothing burns, deodorizing wounds. Use this coupon for samples. Rystan

Chloresium Ointment
Brand of water-soluble chlorophyll derivatives

RYSTAN COMPANY (F)
117 Mt. Vernon Ave.
Mt. Vernon, New York
Please send me literature and free samples of CHLORESIUM OINTMENT

Dr. _____

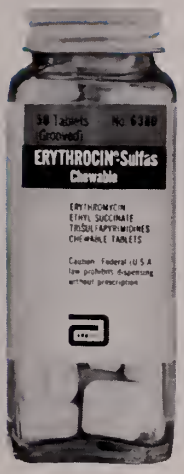
Street _____

City _____ State _____ Zip _____



Perhaps there have been times when you wanted to prescribe erythromycin and triple sulfas for little patients. Now you can—with a choice of two new fine-tasting pediatric forms.

New–Two Pediatric Forms of Erythromycin and Triple Sulfas





ERYTHROCIN®-SULFAS Chewable (Erythromycin ethyl succinate-trisulfapyrimidines chewable tablet)

In clinical trials[1,2], this orange-flavored tablet was given to 55 patients, aged four months to 18 years.

The diagnoses (multiple in some cases) represented a cross section of bacterial infections commonly seen in pediatric office practice.

Therapy was given from three to 12 days, with an average of six days.

Of the 55 patients, 30 were reported cured within 72 hours, while 22 showed partial recovery within the same time, and subsequent clinical cure.

A clinical cure rate of 94.5%

ERYTHROCIN®-SULFAS Granules (Erythromycin ethyl succinate-trisulfapyrimidines granules for oral suspension)

87 patients were treated[1,2]—all children, ages four months to 15 years.

The diagnoses were multiple in some cases and were chiefly bacterial infections of the respiratory tract.

Dosage was maintained from three to 10 days; average treatment was five days. All of the ill children accepted the orange-flavored suspension favorably.

53 were clinically cured within 72 hours, while 32 showed partial relief within the same time, and subsequent clinical cure.

701358

A clinical cure rate of 97.7%

Case Reports on File, Dept. Clin. Development, Abbott Laboratories.
Polley, R.F.L., Use of Erythromycin-Sulfas in Office Practice, Western Med., 7:177, July, 1966.

ABBOTT

Brief Summary on next page

ERYTHROCIN®-SULFAS
Brief Summary

Contraindications: Known sensitivity to erythromycin or sulfonamides. Because of the possibility of kernicterus with sulfonamides, do not use in pregnancy at term, premature or newborn infants.

Warnings: As with other forms of sulfonamide therapy, carefully evaluate patients with liver or kidney damage, urinary obstruction, or blood dyscrasia. Deaths have been reported from hypersensitivity reactions and blood dyscrasias following use of sulfonamides. Perform blood counts and liver and kidney function tests if used repeatedly at close intervals or for long periods.

Precautions, Side Effects: Occasionally mild abdominal discomfort, nausea or vomiting may occur with erythromycin, generally controlled by reduction of dosage. Mild allergic reactions (such as urticaria and other skin rashes) may occur. Serious allergic reactions have been extremely infrequent. Use sulfonamides with caution in patients with a history of allergy. Assure adequate fluid intake to prevent crystalluria and institute alkali therapy if indicated. If overgrowth of nonsusceptible organisms occurs, withdraw the drug and institute appropriate treatment. If a patient should show signs of hypersensitivity, appropriate countermeasures (e.g. epinephrine, steriods, etc.) should be administered and the drug withdrawn.

Adverse Reactions: Sulfonamide therapy may be associated with headache, nausea, vomiting, urticaria, diarrhea, hepatitis, pancreatitis, blood dyscrasias, neuropathy, drug fever, skin rash, injection of the conjunctiva and sclera, petechiae, purpura, hematuria and crystalluria.

Side effects due to erythromycin are infrequent, but occasional abdominal discomfort, nausea, or vomiting, urticaria and other skin rashes may occur.

Supplied: The Granules for Oral Suspension come in bottles of 60 ml. and 150 ml. The Chewable tablets are in bottles of 50. Each 5-ml. teaspoonful of reconstituted Granules or each Chewable tablet provides erythromycin ethyl succinate equivalent to 125 mg. of erythromycin activity and 167 mg. of each of sulfadiazine, sulfamerazine and sulfamethazine.

ABBOTT

701358

VALIUM®
(diazepam)Roche®

Before prescribing, please consult complete product information, a summary of which follows:

Contraindications: Infants, patients with history of convulsive disorders, glaucoma or known hypersensitivity to drug.

Warning: Not of value in the treatment of psychotic patients, and should not be employed in lieu of appropriate treatment.

Precautions: Limit dosage to smallest effective amount in elderly or debilitated patients (not more than 1 mg, one or two times daily initially) to preclude ataxia or oversedation, increasing gradually as needed or tolerated. As is true of all CNS-acting drugs, until correct maintenance dosage is established, advise patients against possibly hazardous procedures requiring complete mental alertness or physical coordination. Driving during therapy not recommended. In general, concurrent use with other psychotropic agents is not recommended. If such combination therapy is used, carefully consider individual pharmacologic effects—particularly with known compounds which may potentiate action of Valium (diazepam), such as phenothiazines, barbiturates, MAO inhibitors and other antidepressants. Advise patients against simultaneous ingestion of alcohol or other CNS depressants. Safe use in pregnancy not established. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Observe usual precautions in impaired renal or hepatic function. Periodic blood counts and liver function tests advisable in long-term use. Cease therapy gradually.

Side Effects: Side effects (usually dose-related) are fatigue, drowsiness and ataxia. Also reported: mild nausea, dizziness, blurred vision, diplopia, headache, incontinence, slurred speech, tremor and skin rash; paradoxical reactions (excitement, depression, stimulation, sleep disturbances, acute hyperexcited states, hallucinations); changes in EEG patterns during and after drug treatment. Abrupt cessation after prolonged overdosage may produce withdrawal symptoms (convulsions, tremor, abdominal and muscle cramps, vomiting, sweating) similar to those seen with barbiturates, meprobamate and chlordiazepoxide HCl.

Dosage—*Adults:* Mild to moderate psychoneurotic reactions, 2 to 5 mg b.i.d. or t.i.d.; severe psychoneurotic reactions, 5 to 10 mg t.i.d. or q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; muscle spasm with cerebral palsy or athetosis, 2 to 10 mg t.i.d. or q.i.d. *Geriatric patients:* 1 or 2 mg/day initially, increase gradually as needed and tolerated. (See Precautions)

Supplied: Valium® (diazepam) Tablets, 2 mg, 5 mg and 10 mg; bottles of 50 and 500.

ROCHE

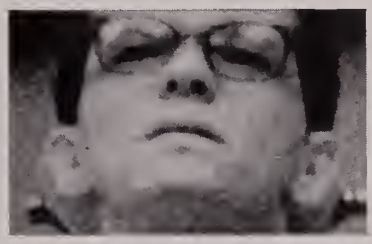
Roche Laboratories
Division of
Hoffmann-La Roche Inc.
Nutley, N.J. 07110





MPORTANT NEW INSIGHTS INTO HUMA
RESPONSE TO EMOTIONAL STRESS:

]ew confirmation of the effectiveness of
'alium® (diazepam)



k your Roche representative to arrange a
esentation of this important and fascinating
search into certain somatic responses to
iotional stress . . . quantitative, objective
easurement with double-blind controls.

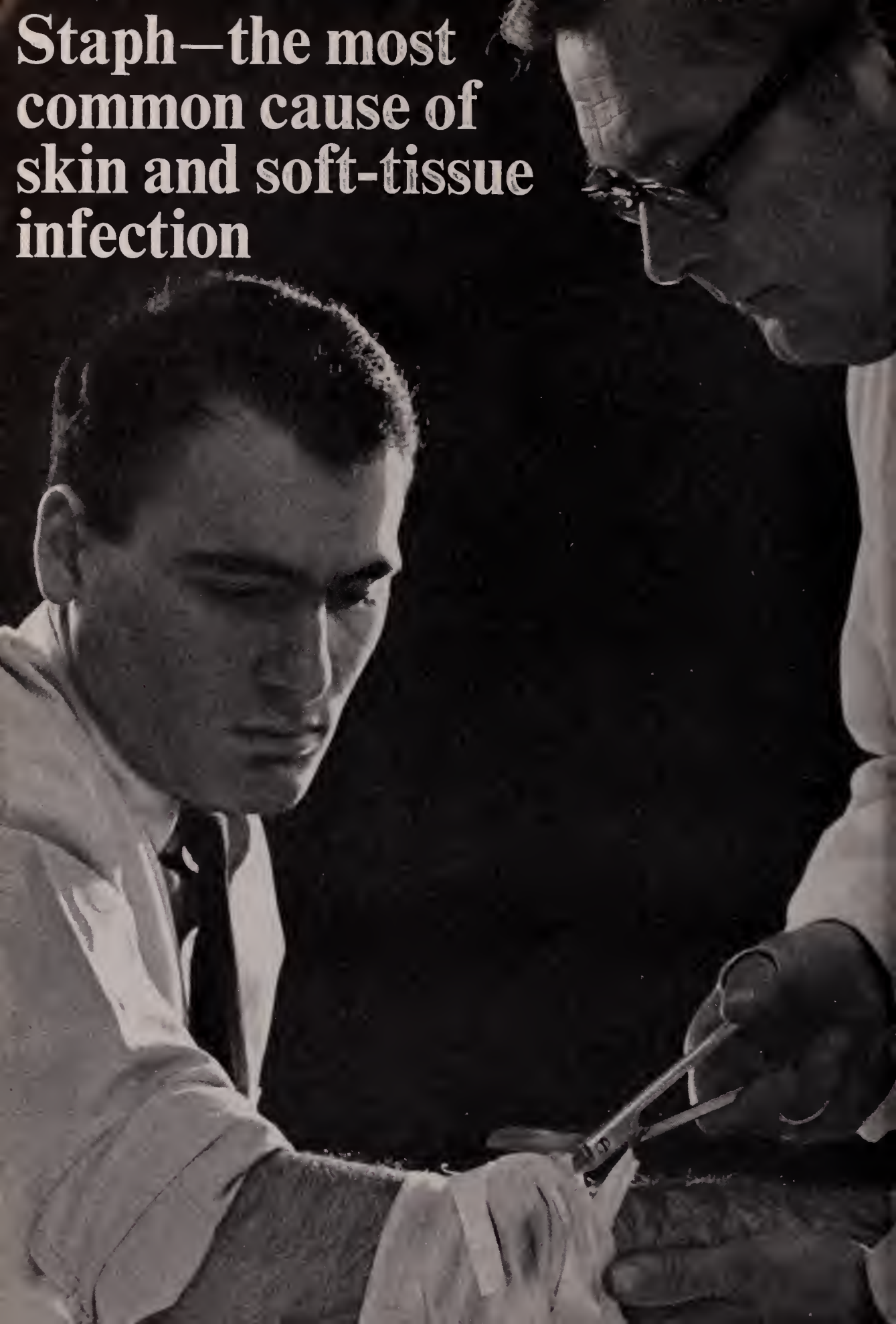


ease see opposite page for important
escribing information.





Staph—the most common cause of skin and soft-tissue infection



reliably controlled with specific therapy



suitable dosage form for every staph situation

aph—the most common cause of skin and soft-tissue fection—also is responsible for many more serious fections, such as pneumonia, osteomyelitis, and pticemia. Often, a seemingly minor skin infection is e source of metastatic spread to deeper structures. hen findings on culture incriminate staph as the use, Prostaphlin (sodium oxacillin) will provide ecific effective therapy.

actericidal effectiveness. Hardly a staph organism n resist the bactericidal action of Prostaphlin (sodi- n oxacillin), as shown by a 34-month *in vitro* study. f all staph isolates tested, 99.5% were sensitive to acillin.[1]

Clinically proven. There is a high correlation between these *in vitro* findings and clinical results. Of 610 patients treated with Prostaphlin (sodium oxacillin), 89.8% were reported cured or improved, including those with staph infections resistant to penicillin G.[2] And since resistance does not appear to develop *in vivo*, therapy with oxacillin can be extended when necessary.

Outstanding safety record. Besides being staph-specific and rapidly absorbed—Prostaphlin (sodium oxacillin) has established an outstanding record of safety during five years of widespread clinical use. Continuous high blood levels of oxacillin have not produced toxic effects on kidney function, assuring a significant margin of safety. However, as with all penicillins, the possibility of allergic response should be considered.

Capsules, Oral Solution and Injectable. Prostaphlin (sodium oxacillin) is available in three flexible dosage forms to suit the age of the patient and severity of infection—capsules, an oral solution for pediatric use, and multi-dose vials for injection, I.M. or I.V.

PRESCRIBING INFORMATION: For complete information, consult Official Package Circular. *Indications:* Infections caused by Staphylococci, particularly those due to penicillin G-resistant Staphylococci. *Contraindications:* A history of severe allergic reactions to penicillin. *Precautions:* Typical penicillin-allergic reactions may occur. Safety for use in pregnancy and premature infants is not established. Because of limited experience, use cautiously and evaluate organ system function frequently in neonates. Mycotic or bacterial superinfections may occur. Assess renal, hematopoietic and hepatic function intermittently during long-term therapy. *Adverse Reactions:* Skin rashes, pruritus, urticaria, eosinophilia, nausea, vomiting, diarrhea, fever and occasional anaphylaxis. Rare cases of reversible hepatocellular dysfunction have occurred. Moderate SGOT elevations have been noted. Thrombophlebitis has occurred occasionally during intravenous therapy and leukopenia was noted in two cases. *Usual Oral Dosage:* Adults: 500 mg. *q.*4 or *q.*6*h.* Children: 50 mg./Kg./day. *Usual Parenteral Dosage:* Adults: 250-500 mg. *q.*4 or *q.*6*h.* Children: 50 mg./Kg./day. Treat beta-hemolytic streptococcal infections for at least 10 days. Give oral drug 1 to 2 hours before meals. *Supplied:* Capsules—250 and 500 mg. in bottles of 48. Injectable—250 mg., 500 mg., and 1 Gm. dry filled vial for I.M./I.V. use. For Oral Solution—100 ml. bottle, 250 mg./5 ml. when reconstituted. **A.H.F.S. CATEGORY 8:12.16**

References: 1. Abstracted from *Antibiotic Sensitivity of Staphylococci Studied from November 1962 through August 1965*, reported by Griffith, L.J., Staphylococcus Reference Laboratory, V. A. Hospital, Batavia, N.Y. 2. Data on file, Bristol Laboratories.

BRISTOL

BRISTOL LABORATORIES/Division of Bristol-Myers Co., Syracuse, N.Y.

Whenever you suspect staph
PROSTAPHLIN®
SODIUM OXACILLIN

when bursitis hits a 280-lb. tackle, hit back with Butazolidin alka



Indications: Osteoarthritis, rheumatoid arthritis, rheumatoid spondylitis, psoriatic arthritis, acute gout, painful shoulder (peritendinitis, capsulitis, bursitis and acute arthritis of that joint), acute superficial thrombophlebitis.

Contraindications: Edema; danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. The drug should not be given when the patient is senile or when other potent drugs are given concurrently. Large doses of Butazolidin alka are contraindicated in glaucoma.

Warning: If coumarin-type anticoagulants are given simultaneously, watch for excessive increase in prothrombin time. Instances of severe bleeding have occurred. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea, sulfonamide-type agents and insulin. Carefully observe patients receiving such therapy. Use with great caution in the first trimester of pregnancy.

Precautions: Before prescribing, carefully select patients, av those responsive to routine measures as well as contraindicate tients. Obtain a detailed history and a complete physical and labo examination, including a blood count. The patient should not e recommended dosage, should be closely supervised and shou warned to discontinue the drug and report immediately if fever, throat, or mouth lesions (symptoms of blood dyscrasia); sudden w gain (water retention); skin reactions; black or tarry stools or evidence of intestinal hemorrhage occur. Make regular blood c Discontinue the drug immediately and institute countermeasures white count changes significantly, granulocytes decrease, or imm forms appear. Use greater care in the elderly and in hyperten

Adverse Reactions: The most common are nausea, edema and rash. Swelling of the ankles or face may be minimized by withh dietary salt, reduction in dosage or use of diuretics. In elderly pa and in those with hypertension the drug should be discontinue the appearance of edema. The drug has been associated with pep

o 280-lb. tackles—or 108-lb. housewives—Butazolidin alka can hasten recovery from the g nizing pain of shoulder bursitis.

' not for every patient. Check carefully the Contraindications, Warning and r cautions shown below.

n adverse reactions may occur. The most common are nausea, edema and rash. a ely, agranulocytosis has been reported. All adverse reactions are listed below, too.

l -for-pay or workaday patients—when they come up with shoulder bursitis and your l ical judgment indicates Butazolidin alka—go with it.

n watch the comeback.



d may reactivate a latent peptic ulcer. The patient should be in- d to take doses immediately before or after meals or with o minimize gastric upset. Mild drug rashes frequently subside eduction of dosage. However, rash accompanied by fever or systemic reactions usually requires withholding medication. ic rash has also been reported. Agranulocytosis, exfoliative titis, Stevens-Johnson syndrome, or a generalized allergic re- similar to serum sickness may occur and require permanent awal of medication. Stomatitis, salivary gland enlargement, ng, vertigo and languor may occur. Leukemia and leukemoid ns have been reported. While not definitely attributable to the a causal relationship cannot be excluded. Thrombocytopenic a and aplastic anemia may occur. Confusional states, agitation, che, blurred vision, optic neuritis and transient hearing loss have reported, as have hyperglycemia, hepatitis, jaundice, and several of anuria and hematuria. With long-term use, reversible thyroid plasia may occur infrequently. Moderate lowering of the red cell due to hemodilution may occur. 6509-V(B)R2

Butazolidin® alka

Capsules

100 mg. phenylbutazone
100 mg. dried aluminum hydroxide gel
150 mg. magnesium trisilicate
1.25 mg. homatropine methylbromide

Dosage in painful shoulder: Initial: 3 to 6 capsules daily in 3 or 4 equal doses. Trial period: 1 week. Maintenance dosage should not exceed 4 capsules daily; response is often achieved with 1 or 2 capsules daily.

For complete details, please see full prescribing information.

Geigy Pharmaceuticals
Division of Geigy Chemical Corporation, Ardsley, New York

Geigy



Public Health Topics

The New Face of Leprosy

The most amazing characteristic of leprosy, perhaps, is its very existence in the face of great adversity. The disease has no particular syndrome to popularize, yet it is as old as recorded history. In the era it was considered a scourge from the Deity, as soon as the condition was recognized the affected person became an outcast awaiting death.

Sophistication in attitudes toward leprosy and persons with the disease is hardly an academic topic, for last year 13 additional cases were diagnosed in Florida. Since 1921 when accurate records were instituted for leprosy, one or two new cases have been reported yearly.

When therapy consisted of chaulmoogra oil, the pertinence of diagnosis was only that the affected person would be extricated from his normal existence and placed in a "colony," seldom to return to society. The introduction of diaminodiphenyl sulfone (DDS) in the early 1940's revolutionized treatment and gave physicians a truly efficacious drug. Thus, early diagnosis became important for the sake of the patient, and the public health.

There is no characteristic early skin lesion. Leprosy should be included in the differential diagnosis of a wide variety of diseases involving the skin and mucous membranes. Anesthesia is a cardinal sign and may precede any visible lesion. Histopathological examination of skin biopsies may confirm the diagnosis. The lepromin test, an intradermal injection of a solution containing Mycobacterium leprae, is not a diagnostic procedure but serves to assess the ability of the host to respond to the organism. Much remains to be learned about the test; however, absence of a reaction to the injection within four weeks indicates lepromatous rather than tuberculoid leprosy and a less favorable prognosis.

It seems likely leprosy is spread by skin-to-skin contact of an infected person with one who is susceptible. The nasal-oral route may be involved. The infectivity of M. leprae must not be great, or population resistance is high. Since much remains to be learned, a broad statement would have little value concerning the benignity of the disease from the public health standpoint; however, principles which apply to other infectious diseases also apply to leprosy. Thus, infectivity is most likely early in the disease and prior to specific therapy. Family and other close contacts are well exposed before the diagnosis is confirmed and, at this point, institutional isolation may be likened to closing the barn door after the horse has escaped.

The inability to culture M. leprae has long been recognized as a major problem. Furthermore, there is no model of the disease in animals. Dr. Charles Shepard, investigator at the national Communicable Disease Center, recently has succeeded in growing M. leprae in the mouse footpad, and much has been learned of the temperature requirements for growth. Work has been done in testing the efficacy of new antileprosy drugs and a tool found to gauge infectivity. Following institution of therapy, the acid-fast organisms lose

the solid staining characteristic and stain in a "beaded" fashion. Beaded M. leprae will not infect the mouse footpad. Thus, it may follow that in treated patients the communicability of the disease is reduced even further than its present low level when the acid-fast organism no longer is solid staining. This phenomenon occurs before total eradication of M. leprae.

Paralleling the sophistication in research, and perhaps associated with it, the medical community in general is assuming more of its responsibility in the care of persons with leprosy. Many Florida physicians are offering comprehensive medical care to these patients. An outpatient clinic is now operative in Miami through the cooperation of public and private medicine.

There are few, if any, areas in medicine in which all the answers are known. We pride ourselves in making an objective, sound judgment on the basis of available data. So, also, let us judge leprosy.

THOMAS E. COLLINS, M.D.
JACKSONVILLE

A COMPLETE BUSINESS SERVICE

FOR THE MEDICAL
AND DENTAL
PROFESSIONS

Professional Management

PM FLORIDA

233 Fourth Ave, N.E.
St. Petersburg, Florida
Phone 898-5074

1855 Hillview Street
Sarasota, Florida
Sarasota Phone 958-4493
4771 Bilmark
Ft. Myers, Florida
Ft. Myers Phone 936-3162

PROFESSIONAL MANAGEMENT FOR PHYSICIANS AND DENTISTS since 1932 PM ©

417 Executive Building
1175 N.E. 125th St.
Miami, Florida 33125
Dade Phone 751-2101
Broward Phone 523-0286

Affiliates of Black & Skaggs Associates
Battle Creek, Michigan



What can be done for Susan Jane To stop the runs and crampy pain?

Parepectolin for quick relief of acute diarrhea
...soothes colicky pain with paregoric
...consolidates fluid stools with pectin
...adsorbs irritants with kaolin, and protects intestinal mucosa

In children, Parepectolin may be used to control diarrhea promptly and prevent dehydration, until etiology has been determined. In some cases, Parepectolin may be all the therapy necessary.

Parepectolin®

Each fluid ounce of creamy white suspension contains:
Paregoric (equivalent).....(1.0 dram) 3.7 ml.
Contains opium (¼ grain) 15 mg. per fluid ounce.
warning: may be habit forming
Pectin (2½ grains) 162 mg.
Kaolin (specially purified)....(85 grains) 5.5 Gm.
(alcohol 0.69%)
Usual Children's Dose: One or two teaspoonfuls three times daily.

RORER

WILLIAM H. RORER, INC.
Fort Washington, Pa.



50 Years Ago in the Journal

September 1917

Fifty years ago this month the Journal was devoted almost entirely to military medical material. The lead editorial, loftily entitled "Medical Preparedness in the Great Drive for Democracy," was written by Joseph Colt Bloodgood, M.D., of Baltimore, chairman of the Committee of Preparedness of the Southern Medical Association. Another major article was the reprinting of a speech by Sen. Robert L. Owen of Oklahoma, author of an amendment to the National Defense Act fixing the ratio of Army medical officers.

Although all of the editorials were concerned with military medicine and the war, one editorial expressed concern with the indirect problem of the Journal and the Association's future as increasing numbers of physicians entered military service. It pointed out that Florida's medical population currently was 1,321 and expressed the hope that a strong organization approaching that figure could be rebuilt with the return of normal conditions at the end of the war.

To help provide readers a figurative feeling of the pulse in September 1917, we reprint the theme editorial of the issue.

A MEDICO-MILITARY NUMBER

This issue of THE JOURNAL is made up entirely of subject matter of medico-military interest and is dedicated to those members of the Florida medical profession who have answered their country's call and aligned themselves with some branch of the military or naval services.

Just as our forms were closing, a report from the Medical Section, Council of National Defense, shows that Florida is well at the head of the list of States in the ratio of physicians to medical population offering their services in the Medical Reserve Corps of the Army with a percentage of 14.6. THE JOURNAL is well pleased with this most excellent showing and takes pride in the fact that it has been an active factor in securing recruits from the profession of the State for a branch of the service whose duty it will be to keep the "Sammies" in good fighting trim.

We wish to especially call our readers' attention to the most excellent and interesting article from the pen of Major Joseph Colt Bloodgood, Medical Reserve Corps, entitled "Medical Preparedness in the Great Drive for Democracy."

This article should be read by every physician in Florida, or better still, by every physician in the United States. Major Bloodgood's interest in, and labor for, the Medical Reserve Corps has been untiring ever since, or even before, it was seen that the necessity had arisen for the creation of an immense medical reserve. An analysis of his article will reveal that he has made a most careful study of the many problems that have to be worked out both by those interested in building up the Reserve and by the individual physician who is confronted with the fact that, to do his duty by his country it is imperative he offer his services to the government.

After discussing the general and special activities of the Red Cross as a part of "Medical Preparedness in the Great Drive for Democracy," Major Bloodgood deals with the opportunities offered the medical man in the present war to build additional monuments to the glory of the medical profession. We are too much inclined in the routine of civil practice to assume that all that is worth while in the broad field of preventive medicine has been worked out and that there is nothing much left to be accomplished. The recent apparent discovery by Doctor Bull, of the Rockefeller Institute, of the antitoxin for the gas bacillus infection is cited by Major Bloodgood as an illustration of the possibilities of research work on the present battlefields of Europe.

The author demonstrates that he has made a careful study of the many vexing problems that confront the individual physician, and while it is not necessary to discuss them in detail, THE JOURNAL is satisfied that many physicians who have for one reason and another held back from placing their services at the disposal of the government cannot, after reading Major Bloodgood's article, conduct careful introspections without at once filing their applications for appointment in the Medical Reserve Corps.

The Surgeon General of the Army has stated that one-fifth or 20 per cent of the medical profession of the United States are required to bring the Reserve Corps up to the required strength. Florida leads now in the percentage of physicians having offered themselves for military duty. Let her be the first to give the required 20 per cent of her medical population to the medico-military service of her country.

G. E. H.

THE DUVALL HOME for RETARDED CHILDREN

A home offering the finest custodial care with a happy home-like environment. We specialize in the care of infants, bed-ridden children and Mongoloids.

For further information write to

MRS. A. H. DUVALL GLENWOOD, FLORIDA

TUCKER HOSPITAL, INC.

212 West Franklin Street

RICHMOND, VIRGINIA

A private hospital for diagnosis and treatment of psychiatric and neurological disorders. Hospital and out-patient services.

JAMES ASA SHIELD, M.D.
GEORGE S. FULTZ, JR., M.D.
CATHERINE T. RAY, M.D.

WEIR M. TUCKER, M.D.
EDWARD W. GAMBLE, III, M.D.
GERALD W. ATKINSON, M.D.



Government News

Heart Study Grants Announced

Surgeon General William H. Stewart recently announced the award of contracts totalling $5,003,348 for the establishment of five specially staffed and equipped units for clinical and laboratory research on acute heart attacks and their complications.

The recipient institutions and their awards are: University of Alabama Medical Center, $1,086,478; Cornell University Medical College, $1,003,242; Duke University School of Medicine, $1,070,000; Johns Hopkins University, $800,000, and Massachusetts General Hospital, $1,043,628.

These are the first of 10 to 12 such units that will eventually be established under the National Heart Institute's Artificial Heart-Myocardial Infarction (AHMI) Program. The goal of this program is to combine bioengineering and biomedical research and development in a two-pronged assault on the Nation's most critical health problem, the acute heart attack. It is estimated that as many as 750,000 Americans may suffer heart attacks each year and that more than 350,000 die from them.

The special units, called Myocardial Infarction Research Units, will combine the finest in patient care with intensive clinical, physiological, biochemical and related studies on the acute phase of heart attacks. This phase, beginning with the onset of the attack and lasting four to five days, is the period of greatest risk.

Another goal of the AHMI Program is the development of a more suitable animal model for the study of coronary heart disease and the acute heart attack. Experimental studies in the laboratory will be a vital supplement to the clinical studies. They will make possible more detailed observations than are presently possible in patients and the thorough testing of new therapeutic measures that appear to hold clinical promise.

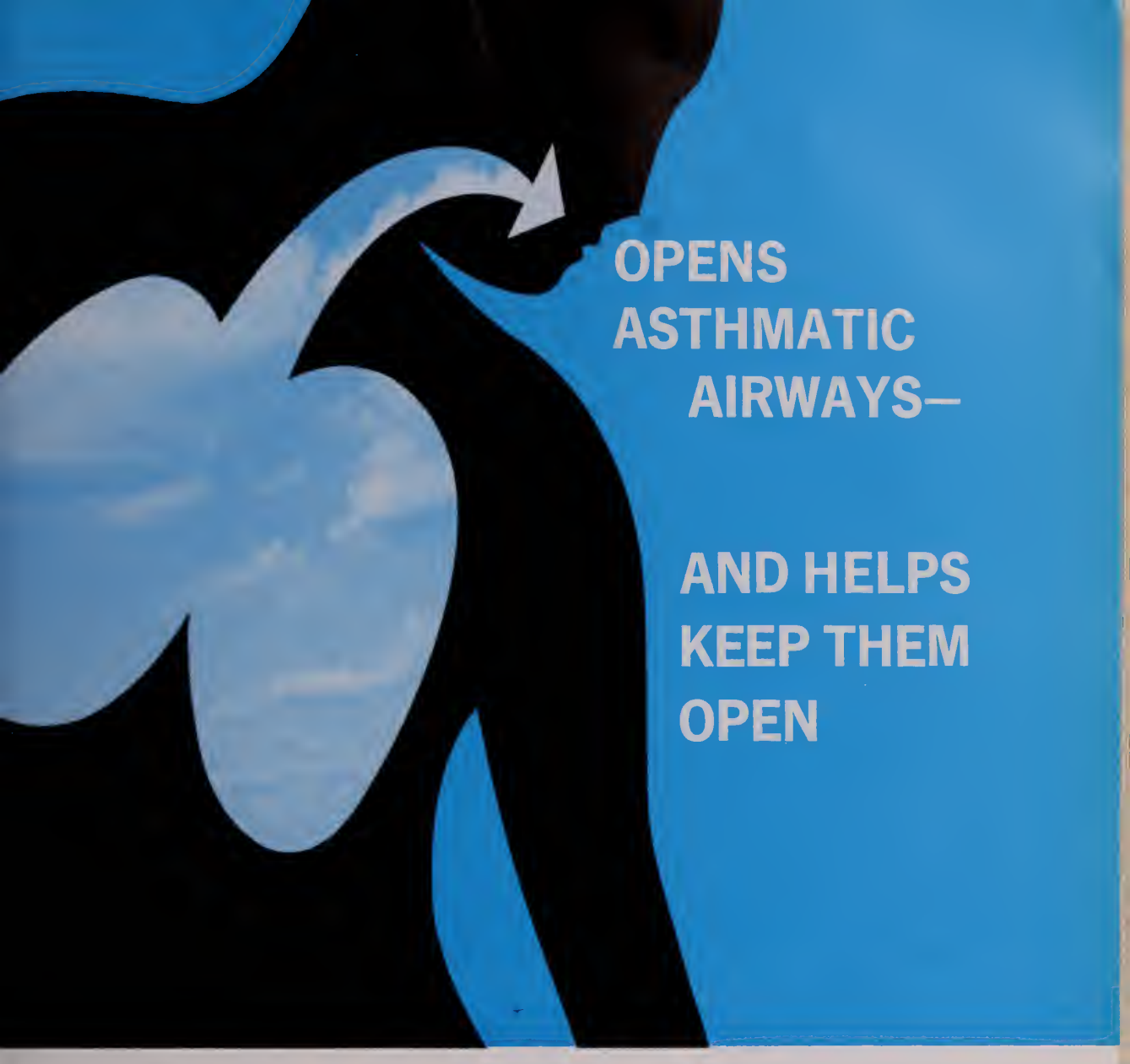
Each Myocardial Infarction Research Unit will consist of a clinical unit in the patient-care area of the hospital. It will have one or more hospital beds with instrumentation and equipment for the most comprehensive care and detailed study of critically ill patients. Additional beds will permit less intensive study of patients over a period of days. Because these units will be operating around the clock, they will require a large staff of expert clinical investigators who are also experienced physicians, and they will need specially trained nursing and technical personnel.

The research programs to be carried out in the five units will be identical in some particulars, but will differ in others. All units, for example, will conduct detailed clinical and physiological studies concerned with defining the course of the acute heart attack, identifying those factors that may critically affect the outcome and with evaluating accepted as well as new therapeutic measures.

All units will carry out detailed autopsy studies on those patients who succumb and will attempt to correlate the location and extent of heart muscle damage and other findings obtained by direct observation with clinical and physiological data recorded while the patient lived.

All units will seek more effective methods for recording, digesting, integrating and retrieving the voluminous data that will be assembled in each study patient.

The units will supplement their clinical studies with laboratory research in experimental animals.



NUMA® DURA-TABS®

for *prolonged* aid to ventilation

Each Numa Dura-Tab provides:

theophylline	225 mg.
ephedrine HCl	50 mg.
butabarbital	25 mg.

(Warning: butabarbital may be habit-forming.)

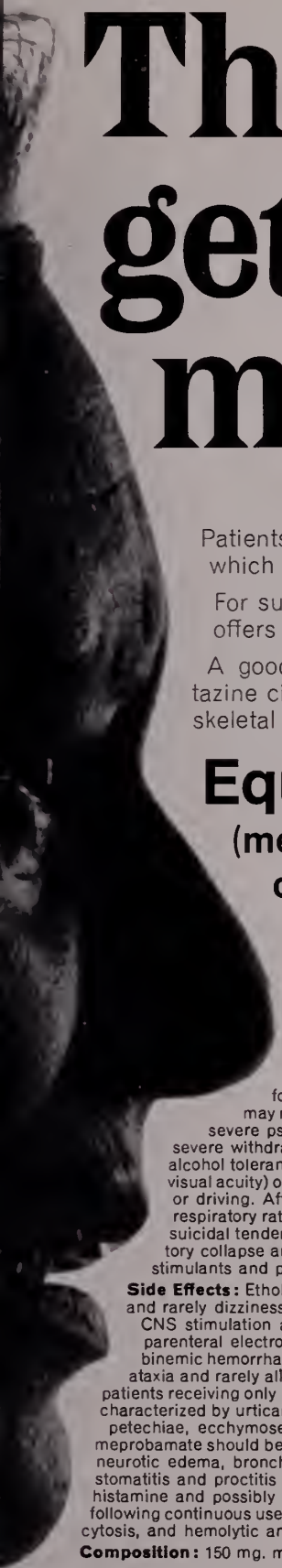
Numa Dura-Tabs provide *prolonged* three-way action to ease breathing. Theophylline, a potent bronchodilator with minimal effect on the CNS, opens air passages and reduces bronchial spasm. Ephedrine HCl improves breathing capacity through its decongestant action. Butabarbital, a mild sedative, allays fear and apprehension.

Dosage: One Numa Dura-Tab every 8 to 12 hours helps keep the asthmatic patient symptom-free all day/all night.

Precautions: Use with caution in cardiovascular or hyperthyroid disease, severe hypertension, circulatory collapse, prostatic hypertrophy, or glaucoma.

WYNN Pharmaceuticals, Inc. Phila., Pa. 19132 • Manufacturers of QUINAGLUTE® DURA-TABS®
(QUINIDINE GLUCONATE 5 gr.)





This pain is getting on my nerves.

Patients in pain often experience concomitant anxiety and tension, which may add to the burden of pain.

For such patients, you may want to prescribe a preparation that offers more than simple analgesia.

A good choice is often EQUAGESIC® (meprobamate and ethoheptazine citrate with aspirin). It helps relieve pain. And anxiety. And skeletal muscle spasm as related to pain or anxiety and tension.

Equagesic® TABLETS

(meprobamate and ethoheptazine citrate with aspirin)

Wyeth

Contraindications: History of sensitivity or severe intolerance to aspirin or meprobamate.

Warnings: USE IN PREGNANCY: Safety for use during pregnancy or lactation has not been established; therefore it should be used in pregnant patients or women of child-bearing age only when the physician judges its use essential to the patient's welfare.

Precautions: Keep out of reach of children. Not recommended for patients 12 years old or less. Carefully supervise dose and amounts prescribed, especially for patients prone to overdose themselves. Excessive prolonged use of meprobamate may result in dependence or habituation in susceptible persons—as alcoholics, ex-addicts, severe psychoneurotics. Withdraw gradually after prolonged high dosage to avoid possibly severe withdrawal reactions including epileptiform seizures. Warn patients of possible reduced alcohol tolerance. If drowsiness, ataxia or visual disturbances (impairment of accommodation and visual acuity) occur, reduce dose. If symptoms persist, caution patients against operating machinery or driving. After meprobamate overdose, prompt sleep, reduction of blood pressure, pulse and respiratory rates to basal levels, and hyperventilation are reported. Give cautiously to patients with suicidal tendencies. Treat attempted suicide (has resulted in coma, shock, vasomotor and respiratory collapse and anuria) with immediate gastric lavage and appropriate supportive therapy (CNS stimulants and pressor amines as indicated).

Side Effects: Ethoheptazine and aspirin may occasionally cause nausea, vomiting, epigastric distress, and rarely dizziness. Overdosage may result in CNS depression (drowsiness and lightheadedness) or CNS stimulation and salicylate intoxication (requires induced vomiting or gastric lavage, specific parenteral electrolyte therapy for ketoacidosis and dehydration, and observation for hypoprothrombinemic hemorrhage [usually requires whole blood transfusions]). Meprobamate may cause drowsiness, ataxia and rarely allergic or idiosyncratic reactions. These reactions, sometimes severe, can develop in patients receiving only 1 to 4 doses who have had no previous contact with meprobamate. Mild reactions are characterized by urticarial or erythematous maculopapular rash. Acute nonthrombocytopenic purpura with petechiae, ecchymoses, peripheral edema and fever have been reported. If allergic reaction occurs, meprobamate should be stopped and not reinstituted. Severe reactions, observed very rarely, include angioneurotic edema, bronchial spasms, fever, fainting spells, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case) and hyperthermia. Treat symptomatically such as with epinephrine, antihistamine and possibly hydrocortisone. A few cases of leucopenia, usually transient, have been reported following continuous use. Rarely, cases of aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis, and hemolytic anemia have been reported; almost always, in the presence of known toxic agents.

Composition: 150 mg. meprobamate, 75 mg. ethoheptazine citrate and 250 mg. aspirin per tablet.

Wyeth Laboratories Philadelphia, Pa.

Convention Press

2111 North Liberty St.
Jacksonville, Florida
32206

QUALITY BOOK PRINTING
PUBLICATIONS BROCHURES

Whatever your first requisites may be, we always endeavor to maintain a standard of quality in keeping with our reputation for fine work — and at the same time provide the service desired. Let Convention Press help solve your printing problems by intelligently assisting on all details.

Anderson Surgical Supply Co.

Established 1916

Distributors of Known Brands of Proven Quality

TELEPHONE 229-8504
Morgan at Platt, P. O. Box 1228
TAMPA, FLORIDA 33601

TELEPHONE 376-8253
236 S.W. 4th Ave.
GAINESVILLE, FLORIDA

TELEPHONE 896-3107
556 9th St., South
ST. PETERSBURG, FLORIDA

TELEPHONE CHerry 1-9589
1818 N. Orange Ave.
ORLANDO, FLORIDA



Ballast Point Manor

5226 Nichols St., P. O. Box 13467 Phone 831-4191
Tampa, Florida

Don Savage, Owner-Manager

Care of mild mental cases, senile disorders and invalids. Alcoholics treated. Aged adjudged cases will be accepted on either permanent or temporary basis.

Dulcolax®

sacodyl

ew drugs work as predictably
s Dulcolax. You can expect
nat when your office patient
akes Dulcolax at home, it will
e as effective as you said it
ould be. Your patient will be
ratified, too.

he reliability of Dulcolax
tems from its unique mode of
ction. The drug works
irectly on nerve endings in
ne colonic mucosa, producing
ormal peristalsis throughout
he large intestine. It does
ot rely on systemic absorption
r its effect.

his reliable action provides
rompt relief of constipation.
also makes Dulcolax par-
ticulary useful for prepping the
bowel for special procedures.
In short, it makes Dulcolax
ideal for your office practice.



Dulcolax acts so surely that the time of evacuation can often be closely predicted. Dulcolax tablets taken at night almost invariably result in a bowel movement soon after waking the following morning. Dulcolax suppositories generally work in 15 to 20 minutes, almost always within the hour.

neral Dosage Information: *Adults:* When an ordinary laxative effect
desired, 1 to 3 tablets or 1 suppository usually suffices. Tablets
st be swallowed whole, not chewed or crushed, and should not be
en within one hour of antacids or milk. *Children:* 1 or 2 tablets,
pending on age and severity of condition. Tablets must not be given
a child too young to swallow them whole. For infants and children
der 2 years of age, half a suppository is usually effective. Above this
a whole suppository is usually advisable. Side Effects: As with any
ative, abdominal cramps are occasionally noted, particularly in severely constipated persons. High dosage may result in loose, unformed stools. Contraindication: Contraindicated only in acute surgical abdomen. Availability: Tablets (5 mg.) and suppositories (10 mg.). By prescription or recommendation.

Under license from Boehringer Ingelheim G.m.b.H.

Geigy Pharmaceuticals
Division of Geigy Chemical Corporation, Ardsley, N.Y.

You may be prescribing Hygroton®, chlorthalidone

You usually prescribe one tablet daily, but every once in a while you like to cut the dosage. So instead of giving the 100 mg. tablet every other day or breaking it in half, why not prescribe the new half-strength tablet every day?

See next page for a brief precautionary statement.

but you don't know the half of it.

New Hygroton 50 mg.

For a clinical supply, please mail us this coupon with one of your prescription blanks.

Geigy Pharmaceuticals
Division of
Geigy Chemical Corporation
Ardsley, New York 10502

DEPT. 7

Broad scope diuretic

Hygroton
chlorthalidone

Hygroton is indicated in certain conditions where the newer nonthiazide diuretics are not recommended, e.g. hypertension, edema of pregnancy, premenstrual edema, edema in obesity states, steroid edema.

However, the newer diuretics are probably superior to Hygroton in acute pulmonary edema and the nephrotic syndrome or any condition where the glomerular filtration rate is significantly low.

Geigy

Indications

Hypertension

Such as hypertension with or without congestive failure, where Hygroton can be used alone or in conjunction with other agents

(*Precaution:* Antihypertensive therapy with Hygroton should always be initiated cautiously in post-sympathectomy patients and in patients receiving ganglionic blocking agents or other potent antihypertensive drugs, or curare. Reduce dosage of concomitant antihypertensive agents by at least one-half. Barbiturates, narcotics or alcohol may potentiate hypotension.)

Edema

Such as edema associated with:
congestive heart failure
or renal disease

(*Precaution:* Because of the possibility of progression of renal damage, periodic determination of the BUN is indicated. Discontinue if the BUN rises.)

or hepatic cirrhosis

(Hypoproteinemia, if present, must be corrected concomitantly. *Precaution:* Take special care: discontinue if liver dysfunction is aggravated, since hepatic coma may be precipitated.)

or steroid administration
or obesity
or the premenstrual syndrome
or pregnancy, including toxemia

(*Warning:* Use with caution in pregnant patients, since the drug may cross the placental barrier and adverse reactions which may occur in the adult, e.g. thrombocytopenia, hyperbilirubinemia, altered carbohydrate metabolism, etc., are potential problems in the newborn.)

Contraindications

Severe Renal or Hepatic Disease and Demonstrated Hypersensitivity

Other general warnings, precautions and adverse reactions

Warning: With the administration of enteric-coated potassium supplements, which should be used only when adequate dietary supplementation is not practical, the possibility of small bowel lesions (obstruction, hemorrhage, and perforation) should be kept in mind. Surgery for these lesions has frequently been required and deaths have occurred. Discontinue enteric-coated potassium supplements immediately if abdominal pain, distention, nausea, vomiting, or gastrointestinal bleeding occur.

Precautions: Electrolyte imbalance, sodium and/or potassium depletion may occur. If potassium depletion should occur during therapy, Hygroton should be discontinued and potassium supplements given, provided the patient does not have marked oliguria.

Take special care in severe ischemi heart disease and in patients receivi corticosteroids, ACTH, or digitalis. Salt restriction is not recommended.

Adverse reactions: Nausea, gastric irritation, vomiting, anorexia, consti- pation and cramping, dizziness, wea ness, restlessness, hyperglycemia, hyperuricemia, headache, muscle cramps, orthostatic hypotension, aplastic anemia, leukopenia, thromb cytopenia, agranulocytosis, dysuria impotence, transient myopia, skin rashes, urticaria, purpura, necrotizi angiitis, acute gout, and pancreatiti when epigastric pain or unexplained G.I. symptoms develop after prolong administration. Other reactions reported with this class of compoun include: jaundice, xanthopsia, paresthesia, and photosensitization.

Average Dosage: 50-100 mg. with breakfast daily.

Availability: White, single-scored tablets of 100 mg. and aqua tablets 50 mg. in bottles of 100 and 1000.

Please see full Prescribing Informa

Geigy Pharmaceuticals
Division of Geigy Chemical Corporat
Ardsley, New York 10502

Gebauer's Ethyl Chloride stops creeping eruption cold





highly magnified drawing of the Ancylostoma Braziliense

Creeping eruption is ugly, uncomfortable, and persistent. And, in Florida, it is seen with considerable frequency.

Creeping eruption is caused by the larvae of the dog and cat hookworm, *Ancylostoma Braziliense*. The larvae of this parasite burrow between the superficial layers of the skin, causing much discomfort and characteristic angry eruptions.

Happily, Gebauer Ethyl Chloride sprayed on the affected area for 30 seconds to one minute will usually kill the offending larvae. In difficult cases, it may be necessary to spray for a period of up to two minutes. Improvement and cure generally follow a comparatively few applications.

Next time you treat creeping eruption, treat it with Gebauer Ethyl Chloride. Also highly effective as a topical anesthetic for minor surgery, as in removal of splinters, incision of boils and whitlows, and to alleviate needle pain. May be used for relief of pain such as first and second degree burns, bee stings, sprains and muscle spasm.

GEBAUER PRODUCTS AVAILABLE AT

CORAL GABLES: Surgical Equipment Co. JACKSONVILLE: Central Medical & Surgical Supply • Hermax Corporation • Medical Supply Co. of Jacksonville • Surgical Supply Co. MIAMI: Amedic Surgical Co. • Florida Physicians Supply • Medical Supply Co. ORLANDO: Anderson Surgical Supply Co. • Medical Supply Co. ST. PETERSBURG: Anderson Surgical Supply Co. SARASOTA: Anderson Surgical Supply Co. TALLAHASSEE: Southeastern Surgical Supply Co. TAMPA: Anderson Surgical Supply Co. • Medical Supply Co. • Southern Surgical Supply Co. • Surgical Equipment Co. of Florida. WEST PALM BEACH: Medical Associates Corp. • Medical Supply Co.

OR YOUR LOCAL PHARMACY

Gebauer's

GEBAUER CHEMICAL COMPANY

9410 St. Catherine Ave. • Cleveland, Ohio 44104

The Mediatric® Age:

Many patients, with or without a functional illness, show symptoms
an aging metabolism: disinterest…lassitude…vague aches and pair

Mediatric® can help them lead a more active, useful li



ndidates for Mediatric

nonly heard complaints from your geriatric pa- may indicate an underlying disorder that may e immediate attention—and definitive therapy. ith or without an underlying functional illness, tients' physical and emotional well-being may nanced by adjunctive steroid-nutritional ther- That's why so many patients just like these are le candidates for MEDIATRIC from their very sit.

eroid-nutritional compound (Mediatric) was n 100 patients to relieve some of the symptoms l by degenerative changes of aging...." This y resulted in improvement of 75 per cent of the ts.

ill, A. J.: Clin. Med. *8*:518 (Mar.) 1961.

The estrogen component is PREMARIN® (conjugated estrogens—equine), the orally active, natural estrogen most widely prescribed for its physiologic and metabolic benefits. The combination of estrogen and *methyltestosterone* can help maintain an anabolic balance to forestall premature estrogen-related degenerative changes.

MEDIATRIC also supplies a small amount of *methamphetamine* to provide a gentle mood uplift; and nutritional supplements specially selected to meet the needs of the aging.

MEDIATRIC helps keep the older patients alert and active; helps relieve general malaise, easy fatigability, vague pains in the bones and joints, and lack of interest so often associated with declining gonadal hormone secretion.

INDICATION: Carcinoma of the e, due to methyltestosterone ent.

G: Some patients with pernicious may not respond to treatment e Tablets or Capsules, nor is ces- f response predictable. Periodic ations and laboratory studies of ous anemia patients are essential ommended.

FECTS: In addition to withdrawal bleeding, breast tenderness or hirsutism may occur.

SUGGESTED DOSAGES: **Male and female:** 1 Tablet or Capsule, or 3 teaspoonfuls Liquid, daily or as required.

In the female: To avoid continuous stimulation of breast and uterus, cyclic therapy is recommended (3 week regimen with 1 week rest period—Withdrawal bleeding may occur during this 1 week rest period).

In the male: A careful check should be made on the status of the prostate gland when therapy is given for protracted intervals.

SUPPLIED: No. 752 – MEDIATRIC Tablets, in bottles of 100 and 1,000.

No. 252 – MEDIATRIC Capsules, in bottles of 30, 100, and 1,000.

No. 910 – MEDIATRIC Liquid, in bottles of 16 fluidounces and 1 gallon.

Steroid-nutritional compound

	Each MEDIATRIC **TABLET or CAPSULE** contains:	Each 15 cc. (3 teaspoonfuls) of MEDIATRIC **LIQUID** contains:
Conjugated estrogens—equine (PREMARIN®)	0.25 mg.	0.25 mg.
Methyltestosterone	2.5 mg.	2.5 mg.
Methamphetamine HCl	1.0 mg.	1.0 mg.
Cyanocobalamin	2.5 mcg.	1.5 mcg.
Intrinsic factor concentrate	8.0 mg.	–
Thiamine HCl	–	5.0 mg.
Thiamine mononitrate	10.0 mg.	–
Riboflavin	5.0 mg.	–
Niacinamide	50.0 mg.	–
Pyridoxine HCl	3.0 mg.	–
Calcium pantothenate	20.0 mg.	–
Ferrous sulfate exsiccated	30.0 mg.	–
Ascorbic acid	100.0 mg.	–
		(Contains 15% alcohol)

Mediatric® tablets • capsules • liquid

AYERST LABORATORIES • New York, N.Y. 10017 • Montreal, Canada

Ayerst



Special Article

Liberal Abortion Laws: The Antithesis of the Practice of Medicine

EDWARD J. LAUTH JR., M.D.

In May 1966, the House of Delegates of the Florida Medical Association approved a committee recommendation that a revised abortion law, utilizing the principles approved in a modified law by the American Bar Association, be introduced into the 1967 session of the Florida Legislature. As a member of the Florida Medical Association, I have expressed the strongest opposition to this resolution, and I have actively urged the Legislature to defeat this liberalization of abortion laws in Florida. This defeat was finally accomplished due to the strenuous efforts of many persons, both inside and outside of our Association.

It has always been the duty and obligation of the physician from time immemorial to do all that he can to preserve life and never to take an innocent life. I, of course, recognize that there are those amongst us, in the medical profession, who think that under certain rigid circumstances, this obligation is to be set aside. They reason that, as a matter of fact, a human being is not present until a "certain" stage of development of the embryo. I do not wish at this point to debate that particular issue, but I will comment later on in this report upon the reasoning behind that particular statement. I do not deny these physicians their opinion; however, I believe that a careful study of the situation reveals, aside from the obvious moral problem involved, a defeatist attitude on the part of the physician and in those segments of organized medicine which support them.

For example, let us assume a theoretical case where an early pregnancy really threatens the life of the mother. In my opinion, it is the obligation of the attending physician to conduct himself as a physician, as a healer, and do all that he can to save both lives, utilizing all of his skills and those of his colleagues in so doing. On the other hand, he could solve the problem by aborting the fetus—a rather simple way out, a quick way out, one that does not tax his skills and one that does not involve much of his time and effort through the long months ahead. But it is also an approach which involves a deliberate attack with intent to kill upon an innocent human life. This is, of course, according to many of us, an immoral approach. It is certainly not the best of medical practice, and it smacks of a real defeatist attitude amongst those who propose such action.

Let us look for a moment at what has been proposed. The present law states that an abortion

may be performed only when the life of the mother is in grave danger. The new law would carry this further. Instead of just the grave danger to the life of the mother, they would now allow that an abortion be performed where there is risk to the health and mental well-being of the mother; they would allow it in cases of rape and incest, and in the situations where the child might be born with a grave mental or physical defect. This proposed law is the most loosely written and vague document ever proposed by supposedly intelligent persons. First of all, nowhere in the law are the constitutional or civil rights of the child considered. It is on this basis that I most strenuously object to its enactment. I am not a lawyer, of course, nor are most of the members of the medical profession; but I know that the unborn has been recognized in the past, under numerous instances in law, to have legal rights from the moment of conception.[1]

For example, this has been so decided in inheritance cases, and more recently in negligence cases where a woman involved in an accident while pregnant can, and often does, claim compensation for injuries that might be suffered by her child. I would also like to point out that, in the law as proposed, and in our present law, the child is actually recognized as a person, for the term "manslaughter" is used here and in all of the laws dealing with abortion. Therefore, whether or not we, as physicians, might recognize the unborn fetus in the early stages as a human being, the law actually recognizes the fetus as a human being. After all, you cannot commit manslaughter against a thing or an appendage. What we are talking about, then, is the killing of an innocent human being. There are problems also arising with informed consent in this proposal. There also are poor definitions in the law, or actually no definitions at all. What is, for example, a grave risk to the physical and mental health of the mother? What is the possibility of grave physical or mental defect to the child? Who, in all honesty, is really competent to decide? Any two physicians?

We all know that there is now a law on the books in Florida which permits the performance of an abortion where the life of the mother is threatened. I think it is noteworthy that no physician practicing in a recognized hospital has been prosecuted in Florida for performing an abortion, even when acting under the spirit of the law. We have heard doctors testify before various committees and say that so-called therapeutic abortions are being done now, and yet we see that there are no prosecutions in these cases. This is not only true in Florida, but it is true throughout the United States where no physicians practicing under similar circumstances have been prosecuted in the past 25 years, under the law as it is written. It is obvious, therefore, that the spirit of the law is being observed by the lawyers and district attorneys. It seems clear that present obstetrical practice has been in accordance with the spirit of the law as it is interpreted today. In written form, the laws are to be considered a general guide line for what is permissible, rather than rules adaptable to year to year changes in obstetrical practice. I submit that it is preferable to keep the responsibility governing abortion in the legal profession, which is somewhat removed from the pressures inherent in the patient-doctor relationship than it is to yield the burden to the physician on the firing line. It seems to me that the most pertinent reason given for the liberalization of the law is so that doctors do not feel "comfortable" performing abortions now, since they are not according to the exact letter of the present law. I submit that whether the physician should be comfortable or not is entirely irrelevant if the law is being written for the protection of some common good. As a matter of fact, the destruction of the unborn should never be a comfortable matter.

Proponents for this particular type of legislation, which is based upon a portion of the uniform code proposed by the American Law Institute, would have you believe that such a law will solve the problem of the illegal abortionists and rid us of these undesirable practitioners in our midst. It does not take more than a cursory reading of this law to show that nowhere does the law permit abortions to be done "carte blanche" on young ladies who conceive out of wedlock, or even married women who simply do not want more children. These cases would, in fact, continue to seek the services of an illegal practitioner as would others. In fact, one of the arguments that has been used in public for the necessity of passing this present proposal is that it would rid us of the vicious illegal abortionists who prey upon women in trouble. There is little doubt that these men are vultures, and that they are an evil which society must not tolerate, but even the proponents of this bill do not think that its passage would rid us of the vicious illegal abortionist. Historically, we have some concrete evidence that the abortionist does not disappear from the scene. As a matter

of fact, in the countries of Japan, Hungary and Sweden where abortions are easy, the incidence of illegal abortion has risen out of proportion to that of legal abortion—so much so that each of these countries is now concerned about changing their laws back to a more rigid interpretation and making other efforts to get rid of the illegal abortionist.

One particular set of figures bears close scrutiny, as was pointed out by Dr. Andre Helligers of Johns Hopkins.[2] It has been repeatedly stated that there are 1.2 million illegal abortions in the United States each year, and 10,000 women die as a result of them. This means that one in 80 patients who walks into an abortionist's office is going to die. If this were true, then it seems to me that the modern abortionist should have been out of business in no time. I think, therefore, that we had better look closely at the derivation of these figures. We find that they come from a study done in 1934. This study was based upon case histories taken from 10,000 women attending a birth control clinic in New York City between the years of 1925 and 1929. This particular group was not even a representative group when compared to the general population of the United States. According to this study, one illegal abortion was recorded for every 3.55 births. We know today that there are now four million live births in the United States annually; therefore, there must be 1.2 million illegal abortions. I doubt that any first year student in high school statistics would pass the course if he attempted to draw conclusions about the United States from such a sample, and yet this is the figure that is being constantly bandied about in the press regarding illegal abortions. The 10,000 deaths that are recorded are derived in an even more questionable and ridiculous fashion. A study in 1936 used the data from the birth control clinic in New York City and combined them with figures from 81 country doctors. By doing so, they arrived at a total of 681,000 abortions in the United States against 2.4 million live births. This again yielded the familiar 1.2 million illegal abortions for the present four million live births. Then they used a "guessed at" mortality rate of 1.2 deaths per hundred abortions based upon an equally questionable German study, and by mathematical maneuvers arrived at 8,000 deaths from abortions per year. Next, they capped this with the sentence, "A maximum of 10,000 abortion deaths in this country is nearer the truth."

If these studies were a wonder in themselves, it is even more remarkable that the figures are still being used today. Finally, the vast majority of deaths from abortion are due to infection, and these studies were done at a time long before antibiotics were available.

I would also like to point out the results of the Florida Maternal Mortality Survey 1964-1965, in which it was stated that although the legislation is important, "it will not solve the problem of criminal abortion. . . . The primary function that the medical profession must provide is the means by which these women who will subsequently feel the need to seek a criminal abortion can prevent pregnancy in the first place."[3]

Now, let's look at the first group of cases that would come under this new proposal, that is, the cases in which the mother's mental health would be endangered. This particular group would open a whole "Pandora's box" of cases and could lead to a situation where, with subtle change in emphasis from the physical to the mental health of the mother, we are faced with a situation in which the legal indications change subtly from the preservation of life to the preservation of happiness. We have a choice in the case of rape-induced pregnancy: We can either kill the child, or we can direct all of our efforts and ingenuity toward smoothing the way for both the distressed mother and the child. It might even be advantageous to pass a law whereby the state would supply funds to take care of the products of such a union and see that this child is born under favorable conditions, adopted and reared, if necessary with the aid of state funds. The case of incest should be handled in much the same way. This certainly is a much more humane solution, and I suppose we are all seeking the humane solution.

For some of us, however, the purposeful destruction of an innocent human life as the means of accomplishing a desirable social end can never be truly human or moral, and this is what we are faced with. The proponents of the liberalized abortion laws are, in fact, asking doctors to solve social problems by performing abortions. We physicians were not brought up to do this; it was not part of our ideals when we entered the profession of medicine, and I do not think that physicians should be put upon to perform abortions in order to solve social problems. I think that the physicians should conduct themselves as physicians and healers in these cases.

Most certainly, abortions will not remove the cause of rape, of incest, of mental disorder or of deformed babies. Besides, I understand that it is perfectly good acceptable medical practice for a girl who is raped to present herself to a physician immediately. The physician will then take her to a hospital where a D and C can be done, and at the same time, if the doctor believes in these devices, he could insert an IUD. It would be virtually impossible for such a girl to become pregnant. The few cases where pregnancy does occur, I believe, were probably not handled properly in the first place; or perhaps these are girls who are raped easily. It certainly would seem to me that any girl who was raped should have the benefit of good medical care immediately after the rape. This would permit the performance of a uterine scraping and any other procedure the doctor thought advisable and it would be well within our existing laws.

Now, let's look at the final category, that is, where there is a good possibility that the child will be born with a grave physical or mental defect. Here, again, I am of the opinion that these cases are best handled by allowing them to go to term. If there is overwhelming expense involved, a law could be passed allowing the state to supply funds to take care of babies who are so deformed or mentally defective. There is little that science can ever learn about defects produced by disease, drugs or trauma if we are continually killing these babies in utero. Much more can be learned by a protracted scientific study of these cases during and after pregnancy. Etiology and positive therapeutic approaches have always been found in this manner. The indication for abortion in the possibly deformed baby case, I think, is one of the most frightening because it is, in fact, a recommendation for eugenic abortion, that is, the prenatal destruction of a child on the prognosis that he will be physically or mentally disadvantaged. As a New York State legislator recently said, this is really reverse euthanasia.

There is another aspect to the case that I think we must all recognize and admit. No physician whom I know is omnipotent. Certainly all of our judgements and decisions are fraught with some possibility of human error. It is impossible to say in any given case where a mother has, for example, contracted German measles prior to the third month of her pregnancy that the particular baby she carries will, in fact, be deformed. We must recognize and admit the fact that 85% of the infants are not deformed and most of the deformities are now correctable. The same is true in the drug-induced deformities. We do not know early enough, with certainty, in which cases there will be deformed babies. As one physician suggested, we could always wait until they are born and then, if they are deformed or mentally defective, go ahead and kill them. This sounds barbarous, but the decision is purely a matter of perhaps days or weeks. Furthermore, the answers to these cases will be found in the near future and the law will be obsolete.

The question of whether or not a human being does exist at the moment of conception has been raised frequently in discussion of abortion. It is obvious to many of us from the biological evidence available that a human being does, in fact, exist at this early stage—not recognizable as such, and a little later on in development perhaps somewhat freakish in appearance, but nevertheless, biologically, a human being. I do recognize the fact that there is doubt and debate as to when a human being actually comes into existence. We find in these discussions, however, that we are no longer in the field of science or medicine, but are, in fact, in the field of philosophy, and perhaps it is better to have the philosophers answer for us. If we turn to the philosophers, we find that there are variations of opinion amongst the philosophers also. Where does that leave us? It leaves us in the situation of a man out hunting for deer. Far off in the bush he sees a movement. He does not know whether this is another hunter, or perhaps the deer which he is hunting. May he shoot without knowledge as to which it is? The answer is obvious. It would be incumbent upon him not to shoot until he is certain. He must accept the fact that there is a doubt and not take such violent action until he is certain that the movement in the bush is not that of a human being. This, I believe, is the case against abortion when argued on this point. I, for one, believe that a human life is present from the moment of conception, but I recognize that others will disagree and that there is no positive answer, except in law, at the present time. Action against the unborn on this principle, when there is doubt, would be wrong, and the burden of proof is on the proponents of this legislation to prove a human life is not present.

It seems strange and perplexing to me that as our government is striving to inaugurate the Great Society, with its emphasis on rights, we have some members of our medical profession now moving for the liberalization of abortion which is the absolute denial of the basic right to life. There is something wrong in a culture, civilization and society, when the rights that flow from life become more important than the right to life itself. The sacredness of the right to life must be understood, accepted, appreciated and followed because it is basic and fundamental to civilization. In fact, it is the right to life that is respected by a cultured civilization which differentiates it from the life of the jungle, where assault and murder are characteristic modes of living. The right to life must not be restricted merely to the living, to the strong, to the independent who in some manner can protect themselves from assault and safeguard themselves. This right must also be accorded to the unborn, who is just as much a person, and an individual with rights, as is the living, but who happens to be weak, helpless and unable to protect himself against the assaults of others. He depends for his continued existence, development and birth on the charity and solicitudes of his mother and her physician.

Once a state grants a right to kill the unborn, it is only a short step to the position where the state could order the killing of the unborn and a shorter step to the commanding of the death of living defectives and then of healthy persons. Once abortion has been liberalized, the State can move very rapidly in the direction of having the power to decide who is to be born and who is to be aborted, who is to live and who is to die. That is a right which the State must never have. The wedge must not be inserted which would give the State the right to take an innocent life. We were all appalled by the genocide practiced in Germany in the concentration camps. We were outraged and we attempted to bring justice at the Nuremburg trials to those who were responsible for these deaths either directly or by willful toleration. We, as a nation, thought that the basic rights to life were violated, and we called to Heaven for vengeance. If we respect the basic fundamental right of one who has been born, we must also be consistent and respect the life of one who is a person and is subject to rights even though he has not yet been born.

It has been most distressing to find oneself in public opposition to his own medical association and to colleagues whom one respects. The difficulties and arguments propounded were actually legal and constitutional ones; what we were all speaking about were socioeconomic problems, not real obstetrical and medical problems. The stand of our parent organization, the American Medical Association, is even more distressing because it shows how far astray organized medicine has been led by an emotional campaign from its primary duty to preserve the life and health of all—the sick, the deformed and even the unprotected, innocent unborn.

References

1. Fitzgerald, Joseph M., and Horkan, Thomas A., Jr.: Legal Brief on Proposed Liberalized Abortion Bill (April 17) 1967.
2. Hellegers, Andre E.: Abortion, the Law and the Common Good, Medical Opinion and Review, pp. 85-89 (May) 1967.
3. Mixson, William T.: Florida Maternal Mortality Survey, 1964-65.

▶ Dr. Lauth, 2121 Biscayne Boulevard, Miami 33137.

The AMBAR SCRAPBOOK of Obesity Oddities

FACT & LEGEND



GALLSTONES HAVE BEEN FOUND IN 60% OF PATIENTS WHO WEIGH MORE THAN 300 POUNDS. 45% HAVE DIABETES, AND 15-TO-20% HAVE HIGH BLOOD PRESSURE.

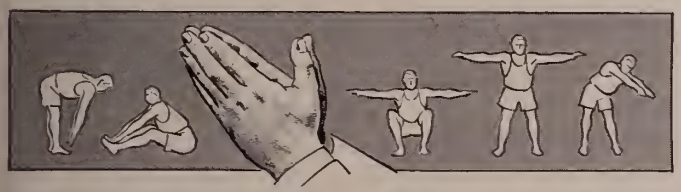
SOURCE: DUNCAN, G.G.: SCIENCE NEWS LETTER, 83:403 (JUNE 29) 1963.

NAPOLEON BONAPARTE

LOST THE BATTLE OF WATERLOO BECAUSE HE WAS TOO FAT!

ACCORDING TO THE NEW YORK TIMES OF APRIL 13, 1890, THE DEFEAT OCCURRED BECAUSE HE FAILED TO CHECK HIS INTELLIGENCE INFORMATION. "IT WAS A MATTER OF MERE INDOLENCE AND THIS INDOLENCE WAS CAUSED BY FAT."

SOURCE: JAMA 186:65 (OCT. 5) 1963.



THE BOOK **"PRAY YOUR WEIGHT AWAY"** URGES READERS TO "ASK GOD TO HELP YOU LIKE EXERCISE" FOR 15 MINUTES A DAY.

SOURCE: REV. C.W. SHEDD: NEW YORK, LIPPINCOTT, 1958.



DIET DROPOUTS

ACCORDING TO DRS. SHIPMAN AND PLESSET "APPARENTLY NO DIETER SUCCEEDS WHO IS VERY ANXIOUS OR DEPRESSED."* THE AMBAR FORMULA PROVIDES **METHAMPHETAMINE** TO HELP **ELEVATE** THE **MOOD** AND **PHENOBARBITAL** TO HELP REDUCE **ANXIETY.**

*SOURCE: ARCHIVES OF GENERAL PSYCHIATRY 8:26 (JUNE 1963).

CONTROL FOOD AND MOOD ALL DAY LONG WITH A SINGLE MORNING DOSE

AMBAR #2 EXTENTABS®

methamphetamine HCl 15 mg., phenobarbital 64.8 mg. (1 gr.) (Warning: may be habit forming).

One Ambar Extentab before breakfast can help control most patients' appetite for up to 12 hours. Methamphetamine, the appetite suppressant, gently elevates mood and helps overcome dieting frustrations. Phenobarbital, the sedative in Ambar, controls irritability and anxiety... helps maintain a state of mental calm and equanimity. Both work together to ease the tensions that erode the willpower during periods of dieting.

Also available: Ambar #1 Extentabs®—methamphetamine hydrochloride 10 mg., phenobarbital 64.8 mg. (1 gr.) (Warning: may be habit forming).

BRIEF SUMMARY/**Indications:** Ambar suppresses appetite and helps offset emotional reactions to dieting. **Contraindications:** Hypersensitivity to barbiturates or sympathomimetics; patients with advanced renal or hepatic disease. **Precautions:** Administer with caution in the presence of cardiovascular disease or hypertension. **Side Effects:** Nervousness or excitement occasionally noted, but usually infrequent at recommended dosages. Slight drowsiness has been reported rarely. See package insert for further details.

A. H. ROBINS COMPANY, RICHMOND, VA. 23220

A·H·ROBINS

Against these three major pathogens...



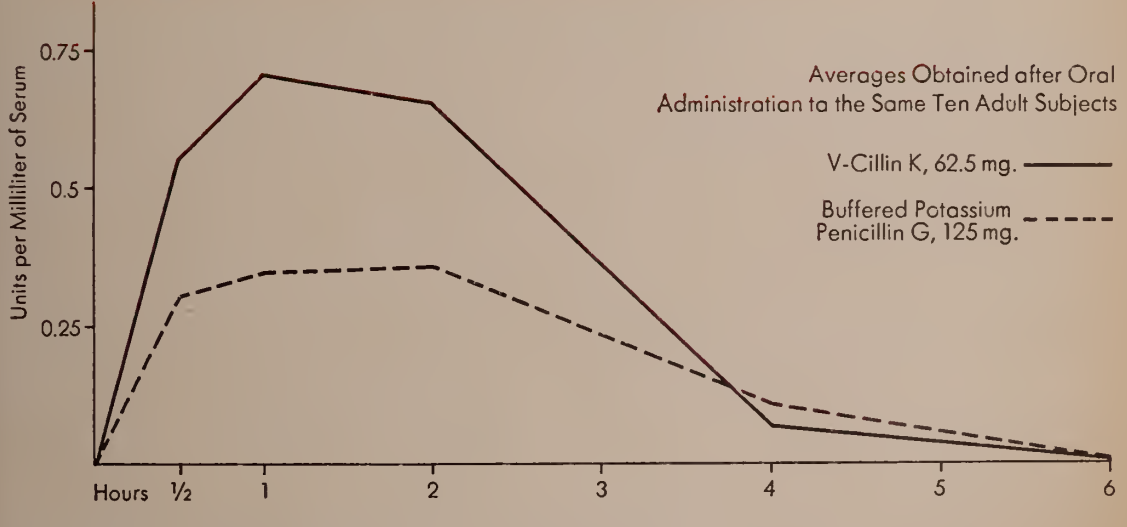
V-Cillin K® provides dependable oral antibacterial activity

because it combines a high degree of in-vitro activity...

Antibiotic	Staph.Aureus (Penicillin-Sensitive) MIC (mcg./ml.) Median	Range	Streptacaccus, Graup A MIC (mcg./ml.) Median	Range	Diplacaccus Pneumaniae MIC (mcg./ml.) Median	Range
Penicillin V	0.02	0.02-0.04	0.02	0.003-0.4	0.01	0.005-0.2
Penicillin G	0.02	0.005-1.6	0.005	0.002-0.2	0.02	0.01-0.1
Methicillin	1.6	0.4-6.3	0.2	0.1-0.4	0.2	0.1-1.6
Oxacillin	0.4	0.1-3.1	0.04	0.02-0.4	0.1	0.04-0.8
Claxacillin	0.2	0.2-0.8	0.1	0.1-0.8	—	—
Nafcillin	0.4	0.2-0.8	0.04	0.02-0.1	0.02	0.02-0.2
Ampicillin	0.2	0.1-0.8	0.02	0.01-0.04	0.02	0.01-0.04

Adopted from Klein, J. O., and Finland, M.: New England J. Med.,269:1019, 1963.

with high blood levels, even in the presence of food



Adopted from Griffith, R. S., and Black, H. R.: Current Ther. Res., 6 253, 1964.

V-Cillin K® Lilly 700867

Potassium Phenoxymethyl Penicillin

(See next page for prescribing informatic

New 500 mg. tablets...a more convenient way to give high doses



Description: V-Cillin K is the potassium salt of V-Cillin® (phenoxymethyl penicillin, Lilly). This chemically improved form combines acid stability with immediate solubility and rapid absorption. Higher serum levels are obtained more rapidly with this penicillin than with equal oral doses of penicillin G. The higher serum levels and acid stability of V-Cillin K make it a more dependable penicillin for oral use.

V-Cillin K, Pediatric, is an oral solution of clinically proved V-Cillin K in teaspoon dosage form. When mixed as directed, each 5 cc. (approximately one teaspoonful) will contain 125 mg. (200,000 units) phenoxymethyl penicillin as the potassium salt.

Indications: V-Cillin K has been shown to be effective in the treatment of streptococcus, pneumococcus, and gonococcus infections as well as infections caused by sensitive strains of staphylococci. It may be used for the prophylaxis of streptococcus infections in patients with a history of rheumatic fever and for the prevention of bacterial endocarditis after tonsillectomy and tooth extraction in those patients with a history of rheumatic fever or congenital heart disease.

Contraindication: V-Cillin K should not be administered to a patient with a history of penicillin hypersensitivity.

Warnings: In rare instances, the use of penicillin may cause acute anaphylaxis which may prove fatal unless promptly controlled. This type of reaction appears more frequently in patients with a history of sensitivity reactions to penicillin and in those with bronchial asthma or other allergies. Resuscitative drugs should be readily available for emergency administration. These include epinephrine and pressor drugs (as well as oxygen for inhalation) for relief of immediate allergic manifestations and antihistamines and corticosteroids for delayed effects.

Precautions: V-Cillin K should be used cautiously, if at all, in a patient with a strongly positive history of allergy.

In prolonged therapy with penicillin, and particularly with g parenteral dosage schedules, frequent evaluation of the renal a hematopoietic systems is recommended.

In suspected staphylococcus infections, proper laboratory st die (including sensitivity tests) should be performed.

The use of penicillin may be associated with the overgrowth pencillin-insensitive organisms. In such cases, its administration shou be discontinued, and appropriate measures should be taken.

Adverse Reactions: Although serious allergic reactions are much les common with administration of oral penicillin than with intramusc a forms, manifestations of penicillin allergy may occur.

Penicillin is a substance of low toxicity, but it does possess a sig cant index of sensitization. The following hypersensitivity react o associated with the use of penicillin have been reported: skin ras e ranging from maculopapular eruptions to exfoliative dermatitis; u caria; and reactions resembling serum sickness, including chills, fe e edema, arthralgia, and prostration. Severe and often fatal anaphyla has occurred (see Warnings). Hemolytic anemia, leukopenia, thro bocytopenia, and nephropathy are rarely observed side-effects a are usually associated with high parenteral dosage.

Administration and Dosage: For Tablets V-Cillin K and for V-Cillin K Pediatric, the usual dosage ranges from 125 mg. (200,000 units) t e times a day to 500 mg. (800,000 units) every four hours. For info the daily dosage may be 50 mg. per Kg. of body weight divided three doses.

Beta-hemolytic streptococcus infections without associated ba teremia may be treated with 200,000 to 400,0000 units three times day. Therapy should be continued for a minimum of ten days to preve development of rheumatic fever and/or other serious complicatio Dosage for routine streptococcus prophylaxis in patients with a histo of rheumatic fever or congenital heart disease may be 200,000 once or twice daily. When such patients undergo tonsillectomy, too extraction, or other minor surgery, the prophylactic dose should b 500,000 units every six hours given two days prior to surgery and two days postoperatively. If oral medication is not feasible on the d of surgery, parenteral therapy should be considered. Mild to mode ately severe pneumococcus pneumonia has been treated effectiv with 250 mg. every six hours.

In staphylococcus infections, 400,000 units or more should be g every six to eight hours in conjunction with indicated surgical proc dures.

For gonorrhea in males, 500 mg. (800,000 units) every four hou s three doses may be employed; in females, 500 mg. every four ho for six doses are recommended. Refractory infections generally respo to a second treatment three to four days following completion of first. Treatment of gonorrhea with severe complications should b individualized, with prolonged and intensive treatment. Patients wit suspected lesion of syphilis should have a dark-field examination b fore receiving penicillin and monthly serologic tests for a minimum three months.

How Supplied: Tablets V-Cillin K, U.S.P., 125 mg. (200,000 units bottles of 50 and 100; and 250 mg. (400,0000 units) and 500 m (800,000 units), in bottles of 24 and 100.

V-Cillin K, Pediatric, for Oral Solution, 125 mg. (200,000 units) p 5 cc. of solution, in 40, 80, and 150-cc.-size packages. [032

Additional information available to physicians upon request. Eli Lilly and Company, Indianapolis, Indiana 46206.

Lilly



Special Article

Rx—Professional Liability

PAUL HAWKINS, CPCU

This special article was prepared at the request of the Association's officers and the Committee on Members Insurance. Adequate protection against the risk of lawsuit in matters of professional liability has been and remains one of the most serious problems facing the medical practitioner. Mr. Paul Hawkins, an experienced insurance underwriter, vividly describes many of the pitfalls to be avoided by the practicing physician, and makes practical suggestions drawn from his background in settling numerous claims. We recommend it for careful reading by every member.

H. Lawrence Smith, M.D., Chairman
Committee on Members Insurance

Physician's professional liability coverage is a most valuable asset; it not only helps relieve the physician's mind from the worry of financial disaster that may result from a well-founded tort claim, but also provides professional help in defending fraudulent or unwarranted claims. In effect, it provides competent and skillful legal talent on a full time basis.

This asset is even more valuable in Florida, a state that is rapidly becoming known as one of the country's high-incident malpractice claims areas. A physician can not fully appreciate the real value of his professional liability coverage until he has been forced to shop in the limited "surplus lines" insurance market for so-called "hard-to-place risks." Physicians who have experienced serious malpractice claims or a frequency of incidents often have had no choice but to turn to this market; the same thing is often true of specialists, even though they have had no claims.

Fortunately, the great majority of Florida doctors may avoid shopping in this limited market, largely because of the foresight exercised by the Florida Medical Association in providing a professional liability facility for its members. In 1960, after 10 years of study and planning, the FMA selected The Employers' Fire Insurance Company of Boston, Mass. to provide this service.

The Employers' Fire Insurance Company, one of the member companies of the Employers' Group of Insurance Companies, has continued to provide coverage to Florida doctors at premiums below standard rates promulgated by the rating bureau. While each risk is individually underwritten, coverage is not denied the practitioners in any specialty field. Underwriting and claims specialists, in cooperation with the FMA, have made this a most effective program.

One factor that has added to the success of the program is the sharing of information developed by The Employers' Company with the FMA. It was agreed that Employers' would provide the FMA with claims statistics and other pertinent in-

Superintendent, Personal Lines Underwriting, Florida-Carolinas Department, Employers Group of Insurance Companies.

formation that might be of value and interest to the members. One such area of information is the claims experience of the FMA program that might lend itself to suggestions in helping physicians avoid malpractice situations. The purpose of this article is to provide suggestions which might prove helpful when applied by each physician to his own particular practice.

Establish Rapport

In the opinion of The Employers' claim department, the single most important factor that enables the physician to avoid a malpractice claim is a good physician-patient relationship. Potentially serious claims have been avoided simply because this rapport has been established. It is highly probable that some incidents which might have occasioned malpractice claims were not reported because the doctor had retained the confidence and respect of the patient. While this fundamental doctor-patient relationship is by far the best "insurance" against malpractice claims, every physician is vulnerable to some extent and would be well advised to consider the following common pitfalls which tend to give rise to such claims and some precautions to be taken against them.

Pitfalls and Precautions

Plaintiff attorneys are quick to determine if examinations and diagnostic procedures necessary to properly diagnose the case were made by the physician. If the physician has not taken these precautions he may find himself vulnerable to attack by the plaintiff's attorney. All such examinations and diagnostic procedures should be recorded in detail on the patient's record. Closely akin to this problem is the matter of whether the physician has the necessary training and experience for treating certain conditions. A recent case was predicated on the fact that the physician treated the patient over a long period of time for a condition that was not within the specialty of the physician and during said treatment the patient's condition became worse. Referral to a specialist or a recorded consultation with a specialist in the field may have lessened the effect of the allegations.

Practices of certain collection agencies have encouraged the patient to present a malpractice claim. Care should be given in the selection of a collection agency to assure that it maintains certain minimum standards of professional conduct. More desirable may be the use of an attorney who specializes in collecting bad accounts.

While on the subject, you may be interested in a related problem encountered in this area. Some situations exist where the patient may be justified in expecting a reduction in charges for services rendered because of an error in treatment. In some cases, the attempt to collect full payment resulted in malpractice claims that were far more bothersome and costly for all parties involved than the delinquent amount being pressed for collection.

Most physicians will readily agree that the presence of a surgical instrument and/or sponge left in a patient after an operation is something that should never occur. These claims, nevertheless, do occur and are the most difficult to defend because of the tangible evidence usually presented. Surgeons should make certain that this function is handled properly by the hospital staff. It is the surgeon's professional reputation that usually suffers from such a mistake. There is some evidence that the situation may sometimes result from a change in hospital staff during the course of an operation. In the event a change of staff occurs during an operation, it is the physician's responsibility to see that the nurse handling the "count" communicates the proper information to the member of the incoming hospital staff responsible.

Physicians are, of course, expected to cooperate with a patient's attorney in supplying necessary evidence for preparing claim reports that will enable the patient to collect benefits. If the physician is suspicious of the nature of the inquiry, he should refer the matter to his own attorney or seek advice from his insurance carrier. Cases have occurred where the physician corresponded directly with the patient's attorney and, as a result, damaged his defense in the suit that followed.

"Uninformed Consent" cases appear to be increasing in frequency. One problem involves extending an operation to remove or overcome conditions not discovered during presurgery diagnosis. Typical of this problem is the necessity for a complete hysterectomy where it was believed that only a partial hysterectomy would be required. In connection with this same problem is the allegation that the patient did not understand the possible adverse effect from a certain type of treatment and/or operation. Where either situation exists, the physician should, where possible, explain these possibilities in the presence of another doctor or a

nurse who can serve as a witness. *It is important that the physician does not guarantee any results.* Some hospitals are protecting their legal liability and that of the physician by requiring a signed authorization for medical services rendered. In using such authorizations, special care should be given to explain the authorization to the patient in addition to reading it to him.

Malpractice Prophylaxis

Your Florida Medical Association has provided you with a Malpractice Prophylaxis. Careful observance of these suggestions should greatly reduce the chances of your becoming involved in a malpractice suit. Information that may assist you in avoiding malpractice action will be provided your Association as claims experience is developed in The Employers' claim department.

A discussion of suggestions to avoid malpractice situations would not be complete without a few brief comments concerning the coverages you purchase. Professional liability insurance is designed to protect you against claims arising from patient relationships. Your professional liability policy also includes coverage for acts or omissions of the insured as a member of a formal accreditation or similar professional board or committee of a hospital or professional society committed in the practice of the insured's profession described in the declarations of the policy during the policy period. General liability coverage is usually obtained also by the physician to provide coverage for injuries not related to professional care received on the insured's office premises. Occasionally a claim will occur where, for example, a patient falls from a chair. A question arises as to whether this should be considered a professional liability claim or a premises accident. When a physician does not have both coverages with the same company, the dispute that could result is obvious. In order to avoid a dispute and the delay that could be involved in settlement of the claim, it is advisable to have both coverages with the same company.

It is especially desirable to have multiphysician groups insured in the same company. Doctor's employees should be covered by the same company as their employer. In the event of a "grey area" claim, separate companies may take differing positions as to whether coverage is available or the legal procedure for handling such a claim. This situation can lead to obvious confusion. Joint defendants insured by different companies using different attorneys often handicap the defense and in some cases may even help the plaintiff's attorney.

In like manner it is advisable, where possible, to have excess limits of liability with the same company providing the primary coverage. Your professional liability policy should be checked to make certain that your insurance contract requires the *written consent* of the physician before a claim can be settled by the insurance company.

Investigation of applicants for coverage has revealed that situations exist where a claim has been settled out of court without the full knowledge of the physician. These settlements were handled in such a manner as to constitute admission of liability on the part of the physician. Have your insurance agent confirm with the company that a malpractice claim against you will not be settled without your written consent. All policies written through the FMA program have this provision.

The Marsh and McLennan Insurance Agency, 950 South Miami Avenue, Miami, is the official servicing agency for the FMA program. Mr. Joe Mozzetta, administrator of the program, will be glad to assist you in any matters pertaining to your insurance coverage.

▶ Mr. Hawkins, P.O. Drawer "S," Jacksonville 32203.

When the problem is only skin deep

USE 'POLYSPORIN'® brand POLYMYXIN B-BACITRACIN OINTMENT

for topical antibiotic therapy with minimum risk of sensitization

Caution: As with other antibiotic products, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

Supplied in ½ oz. and 1 oz. tubes.

Complete literature available on request from Professional Services Dept. PML.

BURROUGHS WELLCOME & CO. (U.S.A.) INC.
Tuckahoe, N.Y.



Hill Crest
HOSPITAL
(Formerly Hill Crest Sanitarium)

7000 5TH AVENUE SOUTH
Box 2896, Woodlawn Station
Birmingham, Alabama 35212
Phone: 205 - 836-7201

A patient centered independent hospital for intensive treatment of nervous disorders . . .

Hill Crest Hospital was established in 1925 as Hill Crest Sanitarium to provide private psychiatric treatment of nervous or mental disorders. Individual patient care has been the theme during its 42 years of service.

Both male and female patients are accepted and departmentalized care is provided according to sex and the degree of illness.

In addition to the psychiatric staff, consultants are available in all medical specialities.



MEDICAL DIRECTOR:
James A. Becton, M.D., F.A.P.A.

CLINICAL DIRECTORS:
James K. Ward, M.D., F.A.P.A.
Hardin M. Ritchey, M.D., F.A.P.A.

HILL CREST is a member of:
AMERICAN HOSPITAL ASSOCIATION NATIONAL ASSOCIATION OF PRIVATE PSYCHIATRIC HOSPITALS . . . ALABAMA HOSPITAL ASSOCIATION . . . BIRMINGHAM REGIONAL HOSPITAL COUNCIL.
Hill Crest is fully accredited by the Joint Commission on Accreditation of Hospitals.

Hill Crest
HOSPITAL
BIRMINGHAM, ALABAMA

DIURESIS



MERCUHYDRIN®
(meralluride injection)

Twenty years ago the publication of "A System for the Routine Treatment of the Failing Heart"[1] established a schedule of diuretic therapy as a primary factor in the treatment of acute congestive failure. With emphasis upon daily injections of Mercuhydrin (meralluride injection) until dry weight was obtained, Gold, et al. achieved a 40% increase in improvement, in ⅓ the time, over other methods then current. Today, most medical texts continue to recommend parenteral mercurials in acute congestive failure when prompt diuresis is indicated.

Recently Modell[2] has stated: "The mercurial diuretics are the injectable diuretics of choice since they are the most potent as well as the most dependable. Their toxicity is not an important consideration either by comparison with other potent diuretics or in relation to the seriousness of the conditions in which they provide such excellent relief."

IN BRIEF

Mercuhydrin is indicated in edema of cardiac or hepatic origin and in the nephrotic syndrome; it is contraindicated in acute nephritis and in anuric or oliguric states. *The usual adult dose is one to two cc. daily or every other day until "dry weight" is obtained.* Sensitivity is rare but small initial doses are advised to minimize potential reactions; vertigo, fever, and rash have occurred. Overdosage may produce electrolyte depletion, muscle cramps, and G. I. reactions. Supplied: 1 cc. and 2 cc. ampuls in boxes of 12, 25 and 100; 10 cc. rubber capped, multiple-dose vials (intramuscular or subcutaneous use only) in boxes of 6 and 100.

1. Gold, Harry, *et al.: A System for the Routine Treatment of the Failing Heart,* The American Journal of Medicine, Vol. III, No. 6:665-692 (Dec.) 1956.

2. Modell, Walter: *Drugs of Choice 1966-1967,* p. 97, 1966.

LAKESIDE

LAKESIDE LABORATORIES, INC., Milwaukee, Wisconsin 53201



when he just can't sleep

Tuinal

One-Half Sodium Amobarbital and
One-Half Sodium Secobarbita
supplied in ¾, 1½, and 3-grain Pulvules



uinal helps wakeful patients fall asleep fast, stay sleep all night.

ndications: Tuinal is indicated for prompt and moderately long-acting hypnosis. It is not suitable for continuous daytime sedation.

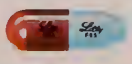
Contraindications: Barbiturates should not be administered to anyone with a history of porphyria, nor should hey be given in the presence of uncontrolled pain, because excitement may result.

Warning: May be habit-forming.

recautions: Tuinal should be used cautiously in patients with decreased liver function, since prolongation f effect may occur.

dverse Reactions: Idiosyncrasy, such as excitement, angover, or pain, may appear. Hypersensitivity reactions occur in some patients, especially in those with asthma, urticaria, or angioneurotic edema.

Overdosage: C.N.S. depression. Symptoms—Depression of respiration and of superficial and deep reflexes, slight constriction of the pupils (in severe poisoning, dilation), decreased urine formation, lowered body temperature, coma. Treatment—Symptomatic and supportive (gastric lavage; intravenous fluids; maintenance of blood pressure, body temperature, and adequate respiration). Dialysis may speed removal of barbiturates from body fluids.



Dosage: 50-200 mg. (¾-3 grains) at bedtime.

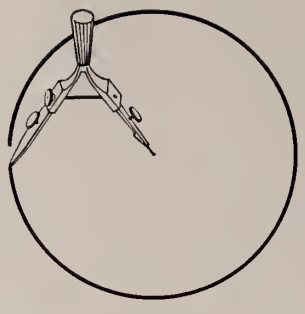
[031767]

Additional information available to physicians upon request.
Eli Lilly and Company • Indianapolis, Indiana 46206

700955

Lilly

Need an office wing?



Consult an architect!

Need an extension?



Call the phone company!

Need optical services?

GUILD Rx OPTICIANS ®

Call on an expert —

YOUR GUILD OPTICIAN!

Specialized services demand specialized knowledge. That's why an architect is consulted when you want the construction you contemplate to be properly planned. It's why you call the phone company when you want your telephone service extended or revised . . . and it's why you should call on your Guild Optician for optical services of any kind.

It's not just by accident that the Guild Optician is an expert. His qualifications are based on knowledge and experience, his will to serve the doctor, his ability to handle not only the routine problems of after-service for your patients, but also the unusual.

When you write a prescription, above all you expect to have that Rx properly filled so the patient obtains the full benefit of your professional services. You also expect to have your patient receive after-service for the life of his glasses. That's why it's wise to call on an expert — your Guild Optician. *Guild of Prescription Opticians of Florida.*

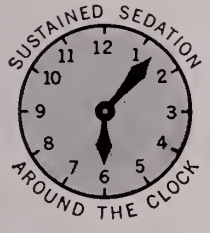
USING GUILD SKILLS AND EXPERIENCE TO SERVE YOUR PATIENTS

removes the mental blur

that clouds vision

SOLFOTON®

Each tablet or capsule contains
PHENOBARBITAL.....16 mg.
(Warning: may be habit forming)
BENSULFOID® (See P D R).....65 mg.
Precaution: same as 16 mg. of phenobarbital



Constructive Therapy

A Solfoton tablet or capsule at 6 hour intervals maintains sedation at the threshold of calmness, sustaining a mental climate for purposeful living.

Literature and clinical samples sent upon request.

FEDERAL LAW PROHIBITS DISPENSING WITHOUT PRESCRIPTION

AVAILABLE

Solfoton *(yellow, uncoated tablets "P")*
100s, 500s, 5000s
Solfoton Capsules *(yellow and brown)*
100s, 500s, 1000s
Solfoton S/C *(sugar-coated beige tablets)*
100s, 500s, 4000s

WM. P. POYTHRESS & CO., INC.
RICHMOND, VIRGINIA 23217
Manufacturers of ethical pharmaceuticals since 1856

In Obesity, anorectic action with fewer unwanted side effects



CYDRIL®
(levamfetamine succinate TUTAG)



Cydril at 2 p.m. Appetite control at 6 Sleep at 10

Action and Uses: Cydril (levamfetamine succinate) is a chemopharmaceutical approach to aid the obstinately obese. Cydril (levamfetamine succinate) provides the appetite depressant action of amphetamines but exhibits fewer unwanted side reactions.

Dosage: Adults and 'teenagers', one (1) Cydril (levamfetamine succinate) Granucap* daily.

Side Effects: Occasionally cardiovascular and gastrointestinal reactions may produce dry mouth, metallic taste, anorexia, nausea, diarrhea, headache, chilliness, pallor or flushing, sweating, diuresis, and arrhythmias.

Contraindications: Cydril (levamfetamine succinate) should not be used in the presence of severe hypertension, angina pectoris, hyperthyroidism, and Raynaud's disease.

*Granucap is the Tutag brand of sustained release capsule manufactured to release the contents over a period of approximately 6 to 10 hours.

Caution: Federal law prohibits dispensing without prescription.

Full product information available on request or see page 1122 in your 1967 PDR.

For more about CYDRIL and the Cydril Family of Products ask the Man from Tutag (or your colleagues)

S. J. TUTAG & CO. ETHICAL PHARMACEUTICALS
DETROIT, MICHIGAN 48234

Thomas B. Slade | Fifty Years in Florida | J. Beatty Williams

Surgical SUPPLY COMPANY

HAMILTON — RITTER — SKLAR — BURDICK
CLAY-ADAMS — B-D — BARD-PARKER — TYCOS
BAUM — WELCH-ALLYN AND MANY, MANY OTHERS

Ph. 355-8391 | P. O. Box 2580 — 1050 W. Adams Street | Jacksonville, Fla. 32203



P. L. DODGE MEMORIAL HOSPITAL

M. G. Isaacson, M.D.
Medical Director
1861 N.W. South River Drive
Miami, Florida
Phone 379-1448

A nonprofit-voluntary hospital for the treatment of nervous and mental disorders and the problems of drug addiction and alcoholic habituation. Modern diagnostic and treatment procedures including—Psychotherapy, Insulin, & Electroshock, when indicated. Adequate facilities for recreation and out-door activities. Admissions are made without regard to race, color or national origin.

Information on request
Member NAPPH, American Psychiatric Assn., & American Hospital Assn.

Highland Hospital

Asheville, North Carolina

Founded 1904

A DIVISION OF THE DEPARTMENT OF PSYCHIATRY
OF DUKE UNIVERSITY

Accredited by the Joint Commission on Accreditation and Certified for Medicare

Complete facilities for evaluation of and intensive treatment of psychiatric patients, including individual psychotherapy, group therapy, psychodrama, electro-convulsive therapy, Indoklon convulsive therapy, drugs, social service work with families, family therapy, and an extensive and well organized activities program, including occupational therapy, art therapy, athletic activities and games, recreational activities and outings. The treatment program of each patient is carefully supervised in order that the therapeutic needs of each patient may be realized.

Complete modern facilities with 85 acres of landscaped and wooded grounds in the City of Asheville.

Brochures and information on financial arrangements available
Contact: Mrs. Elizabeth Harkins, ACSW, Coordinator of Admissions

or

Charles W. Neville, Jr., M.D.
Assistant Professor of Psychiatry and Medical Director
Area Code 704 - 253-2761

APPALACHIAN HALL

ASHEVILLE Established 1916 NORTH CAROLINA



An Institution for the diagnosis and treatment of Psychiatric and Neurological illnesses, rest, convalescence, drug and alcohol habituation.

Insulin Coma, Electroshock and Psychotherapy are employed. The Institution is equipped with complete laboratory facilities including electroencephalography and X-ray.

Appalachian Hall is located in Asheville, North Carolina, a resort town, which justly claims an all around climate for health and comfort. There are ample facilities for classification of patients, rooms single or en suite.

Wm. Ray Griffin Jr., M.D.
Robert A. Griffin, M.D

Mark A. Griffin Sr., M.D.
Mark A. Griffin Jr., M.D.



Classified Advertisements

Advertising rates for this column are $5.00 per insertion for ads of 25 words or less. Add 20¢ for each additional word.

physicians wanted

General Practitioners

GENERAL PRACTITIONER WANTED (AAGP) for north Florida college town. Vacancy in busy two man practice in medicine, pediatrics and obstetrics. Immediate excellent income with eventual full partnership. Write C-614, P.O. Box 2411, Jacksonville, Fla. 32203.

EXCELLENT OPPORTUNITY for general practitioner in community of 15,000; central Florida; 76 bed JCAH hospital. Write or call collect R. C. Thompson, Bartow Memorial Hospital, Bartow, Fla.

WANTED: General practitioner associate, leading to partnership. Practice approximately one half industrial. Ideal central Florida community. Send detailed resume to C-716, P.O. Box 2411, Jacksonville, Fla. 32203.

GENERAL PRACTITIONER wanted to take over for physician going into residency. Beach community of 10,000; 50 bed hospital. Office and equipment available. Write C-745, P.O. Box 2411, Jacksonville, Fla. 32203.

GENERAL PRACTITIONER needed for independent practice within a three man association. Modern office building in Brooksville, Florida. Contains lab, x-ray and adequate personnel. Advantage of group practice without incumbrances of partnership. Call, write or visit R. A. Henry, M.D., Brooksville, Florida 33512.

WANTED: General practitioner to associate with established young doctor. Also office space available for rent. Contact G. L. Ehringer, M.D., 1184 Oceanshore Blvd., Ormond Beach, Florida 32074.

GENERAL PRACTITIONER WANTED: Partner, semi-rural practice in central Florida area undergoing rapid industrial expansion. Spacious, fully equipped office including x-ray. Good income without working yourself to death. Write C-749, P.O. Box 2411, Jacksonville, Fla. 32203.

WANTED: General practitioner and internist to join group for partnership in Miami area. Must have Florida license and fulfilled military obligation. Write Medical Business Consultants, 9999 N.E. 2nd Ave., Miami Shores, Fla. 33138.

GENERAL PRACTITIONER (AAGP) preferred wanted to join a three man partnership. Associate with very generous salary first year, partnership after one year. Excellent income with ample free time for recreation and leisure pursuits. Practice limited to internal medicine, pediatrics, and minor office surgery. Must have Florida license and fulfilled military obligations. Write or visit R. D. Wilson, M.D. or D. B. York, M.D., 1213 W. Hillsborough Avenue, Tampa, Fla. 33603.

WANTED: Young Florida licensed GP or internist to join three man group in West central Florida. Position permanent with future partnership. Write C-764, P.O. Box 2411, Jacksonville, Fla. 32203.

Specialists

PEDIATRICIAN: Board eligible, to join two board pediatricians in rapidly growing Southeastern Florida coastal college town. Early partnership anticipated, excellent hospitals nearby. Send references and curriculum vitae in first letter. C-719, P.O. Box 2411, Jacksonville, Fla. 32203.

OBSTETRICIAN-GYNECOLOGIST WANTED: To associate with two man group. Large established practice in Miami; Board eligible or certified; prefer under age 35. Write P.O. Box 384, Miami Shores, Fla. 33153.

PEDIATRICIAN: Forty doctor multi-specialty group in northwest Florida has opening for board qualified pediatrician under age 40. The group would like to add at least two additional pediatricians as soon as possible. Write to Mr. L. L. Smith Jr., P.O. Box 151, Pensacola, Fla. 32502

INTERNIST WANTED: Preferably young board qualified or certified internist to associate with well established certified internist in Ft. Lauderdale, Florida. Terms open. Send details first letter. Write C 752, P.O. Box 2411, Jacksonville, Fla. 32203.

PATHOLOGIST: Board eligible or certified, association leading to partnership in active general hospital practice. Write C-763, P.O. Box 2411, Jacksonville, Fla. 32203.

INTERNIST WANTED: Associate for a three man partnership. Board qualified or certified. Located in very actively growing part of metropolitan Atlanta, Georgia area. Full partnership possible in 24 months. Write P.O. Box 506, Marietta, Ga. 30062.

PEDIATRICIAN WANTED: North Dade county. Space available in prestige building. Unusual opportunity for board qualified man. Patient flow in building guarantees instant practice. Inquire Mrs. Brecher, 17301 N.W. 27th Ave., Miami 33054.

ANESTHESIOLOGIST: New facility 100 beds has opening for anesthesiologist on its medical staff. Call or write Administrator or Fred H. Albee, M.D., Chief of Staff, Ormond Beach Memorial Hospital, Box 187, Ormond Beach, Fla. 32074.

EXPANDING MULTISPECIALTY CLINIC in Florida needs gastroenterologist, neurosurgeon, orthopedist, otolaryngologist, urologist. Seven man group, state capitol, two universities, 70,000 population. One hour drive to Panama City resort, beautiful rolling hills. Adequate salary first year then partnership. Will equip office. 250 bed hospital 500 ft. away. Resumé to Dr. Gerald N. Bryant, Medical Arts Clinic, Tallahassee, Fla. 32303.

OPPORTUNITY FOR DOCTORS who want to join a multi-specialty group—who want to practice in Florida. A senior surgeon with a large practice and with adequate facilities including laboratory, x-ray and physical therapy departments, desires to confer with board eligible or board certified doctors. The intent is to form a new multi-specialty group practice. Close proximity to a new 500 bed hospital. All inquiries held in strict confidence. Reply to: Jay S. Lombardy & Associates, Management to the Medical Profession, 1177 N.E. 8th St., Delray Beach, Florida 33444.

WANTED: Otolaryngologist, board certified or board eligible to associate with an established otolaryngologist in Miami, Florida. Must have Florida license and fulfilled military obligation. Excellent opportunity—excellent hospitals nearby. Send references and curriculum vitae in first letter. Write C-777, P.O. Box 2411, Jacksonville, Fla. 32203.

INDUSTRIAL: Established clinic needs physician with some surgical and orthopedic training. Eventual partnership anticipated. Write The Mitchell Clinic, 241 W. Ashley St., Jacksonville, Fla. 32202.

situations wanted

BOARD CERTIFIED ORTHOPAEDIC SURGEON seeking association with another orthopaedic surgeon or multi-specialty group in the southeastern coastal Florida area. Age 40. Florida license. Write P.O. Box 126, Oak Lawn, Illinois 60453.

Miscellaneous

WANTED: Full time resident physicians. Contact Administrator, St. Mary's Hospital, West Palm Beach, Florida for particulars.

WANTED: Assistant medical director for medium size Florida based life insurance company. Prefer physician under 40 with Florida license. Write C-760, P.O. Box 2411, Jacksonville, Fla. 32203.

IMMEDIATE OPENING FOR FLORIDA LICENSED PHYSICIANS for the Emergency Room department. Excellent working conditions; salary open; fringe benefits. Contact Mr. S. A. Mudano, Administrator, Memorial Hospital, Hollywood, Florida 33021.

FLORIDA LICENSED PHYSICIANS, DO YOU WANT TO SLOW DOWN? Take life a little easier? Ormond Beach Memorial Hospital has openings on their emergency room medical staff for you. Guaranteed annual income of $18,000. Write either Administrator or Fred H. Albee, M.D., Chief of Staff, Ormond Beach Memorial Hospital, P.O. Box 187, Ormond Beach, Fla. 32074.

PSYCHOSOMATIC MEDICINE: Applicants now being considered for six to twelve months. Accredited fellowships in psychosomatic medicine beginning Oct. 1967 or Jan. 1968. Salary $12,000. Other openings also available at $5,000 to $7,000. Apply to John J. Schwab, M.D. or Michael J. Kehoe, M.D., Department of Psychiatry, University of Florida, Gainesville 32601.

real estate

RENTAL PROFESSIONAL SUITES: Modern professional building. Ideal location. Ample parking. 2,250 sq. ft. or any part available. Will design to tenants specifications. 1300 North Federal Highway, Lake Worth, Fla. Phone 582-1760.

OCEAN FRONT HIGH RISE PHYSICIAN'S SUITE. Eight room ocean front physician's suite available August 15. Seventeen story high rise rental apartment building in Daytona Beach (190 units). This suite may be rented furnished or unfurnished. Excellent opportunity. Contact Resident Manager, The Towers Apartments, 2800 North Atlantic Avenue, Daytona Beach, Fla. 32018. Phone 677-8333.

MEDICAL OFFICE SPACE FOR RENT: Have one large space (1,100 sq. ft.) unfinished. Excellent area with large parking space. At present have five physicians and two dentists. Need one more. For information write or call Harry C. Fults, 615 South Missouri, Clearwater, Fla. 33516. Phone 531-4206.

FOR RENT: Private office suite available in new medical-dental professional building in Hollywood, Florida. Will partition to suit. Write Drs. Peretz and Balick, 2630 Hollywood Blvd., Hollywood, Fla. 33020. Phone 923-2403.

FOR RENT OR LEASE: 1,200 sq. ft., seven rooms, corner of Cassett and Appleton. Private parking plus on street. Contact Mr. Vansandt, Jacksonville. Phone 384-2488.

practices available

FOR SALE: Internal medicine practice, southeast coastal city, Florida. $90,000 gross. New office building. Complete equipment. Share large suite, lab, x-ray and alternate on call with two young certified internists; but own private practice. New hospital. Retiring. Write C-766, P. O. Box 2411, Jacksonville, Fla. 32203.

AVAILABLE: Otolaryngology office. Immediate occupancy. Ideal location. Excellent opportunity. Capable gross $35,000-$50,000 first year. Owner retiring. Sell or lease. Location excellent for general practice. Write C-746, P.O. Box 2411, Jacksonville, Fla. 32203.

The Florida Medical Association offers placement assistance through the Physician Placement Service, P.O. Box 2411, Jacksonville 32203. This service is for the use of physicians seeking locations, as well as physicians seeking associates, and is without charge.

Florida Medical Association

735 Riverside Ave., P. O. Box 2411

Jacksonville, Florida 32203

Officers

W. Dean Steward, M.D., President	Orlando
Jack Q. Cleveland, M.D., President-Elect	Coral Gables
Irving E. Hall Jr., M.D., Vice President	Bradenton
James T. Cook, M.D., Speaker of the House	Marianna
Charles K. Donegan, M.D., Vice Speaker	St. Petersburg
Floyd K. Hurt, M.D., Secretary-Treasurer	Jacksonville
George S. Palmer, M.D., Immediate Past President	Tallahassee
W. Harold Parham, Executive Director	Jacksonville

Councils

Jesse W. Castleberry, M.D., Chairman, Council on Allied Professions and Vocations	Orlando
John J. Cheleden, M.D., Chairman, Judicial Council	Daytona Beach
Jere W. Annis, M.D., Chairman, Council on Legislation and Public Agencies	Lakeland
Jack A. MaCris, M.D., Chairman, Council on Medical Economics	St. Petersburg
James M. Ingram, M.D., Chairman, Council on Medical Services	Tampa
Richard C. Dever, M.D., Chairman, Council on Scientific Activities	Miami
John D. Milton, M.D., Chairman, Council on Special Activities	Coral Gables
Sanford A. Mullen, M.D., Chairman, Council on Specialty Medicine	Jacksonville
Mason Romaine III, M.D., Chairman, Council on Voluntary Health Agencies	Jacksonville

Information for Authors

Manuscripts submitted for publication in the Journal of the Florida Medical Association should be double or triple spaced on white bond, including title page, illustration legends, charts and graphs, table headings, footnotes and bibliography.

Submit original manuscript and two copies. Copying by electrostatic dry process (not wet process) is preferred to tissue copies. Retain one additional copy in your office for proofreading. All material is submitted with the understanding it is subject to editing.

Photographs should be submitted as 5x7 glossy prints, untrimmed and unmounted; number each photograph *lightly* on the back with pencil and indicate top. Charts, graphs and medical illustrations should be submitted as india ink drawings on white gloss paper; remember to make details large enough to allow for photographic reduction. It is a policy of the Journal that authors pay for any cuts made to illustrate their papers.

Titles should be short, specific and clear. Omit phrases such as "The Use of," "Observations on." If paper was presented at a meeting, indicate name of organization, city, month, day and year.

Only original papers not previously published are accepted for publication. Manuscripts submitted for publication are subject to review and approval by the Journal Publications Committee. Except by invitation, only papers from members of the Florida Medical Association are considered for publication.

References should be typewritten, double or triple spaced, beginning on a new sheet of paper entitled "References." Number references in the text in order of citation and prepare bibliography in the same order. Bibliographies should conform to the style of the Index Medicus. The Journal prints only bibliographies of eight references or less; bibliographies of more than eight references are referred to at the end of the paper with the statement "References are available from the author upon request."

All manuscript pages should be numbered consecutively. Within the manuscript, numbers one to nine should be spelled out except when used for units of measurement; for numbers above nine, numerals should be used. Dorland's Medical Dictionary and Webster's International Dictionary may be used as standard references. Scientific names for drugs should be used when possible. Copyright or trade names of drugs should be capitalized.

What's all the fuss about bactericidal?

The ultimate aim in antibiotic therapy is to contain the bacterial colony and eliminate infection. Both 'cidal' agents and bacteriostatic DECLOMYCIN achieve this goal. DECLOMYCIN inhibits susceptible pathogens by stopping their growth; cidal agents affect the pathogens only while they are growing.

Though the two mechanisms differ, the end result is the same—containment of the infecting organism. *However, a very important attribute of any antibiotic is its potency against a broad range of pathogens.* DECLOMYCIN not only offers broad-spectrum potency, but high serum and tissue levels with persistent activity against tetracycline-sensitive organisms. Therapeutic benefits continue for 1-2 days after dosage stops to help prevent relapsing infection.

These are the reasons why so many doctors make DECLOMYCIN their basic broad-spectrum antibiotic. At last count, one billion doses had been administered since its introduction, and the number keeps rapidly growing.

DECLOMYCIN®
DEMETHYLCHLORTETRACYCLINE

Lederle

Prescribing information on next page.

For a wide range of everyday infections—respiratory, urinary tract and others—in the young and aged—the acutely or chronically ill.

True broad spectrum

DECLOMYCIN Demethylchlortetracycline should be equally or more effective than other tetracyclines when the offending organisms are tetracycline-sensitive.

Contraindication: History of hypersensitivity to demethylchlortetracycline.

Warning—In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated, and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort. Necessary subsequent courses of treatment with tetracyclines should be carefully observed.

Precautions—Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects—Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes. A rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney—rise in BUN, apparently dose related. Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth — dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs discontinue medication and institute appropriate therapy.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

Capsules: 150 mg; **Tablets:** film coated, 300 mg, 150 mg, and 75 mg of demethylchlortetracycline HCl.

DECLOMYCIN®
DEMETHYLCHLORTETRACYCLINE

LEDERLE LABORATORIES, A Division of
American Cyanamid Company, Pearl River, New York

Lederle

Index to Advertisers

Abbott Laboratories
Enduron 848a
Enduronyl 848a
Erythrocin Sulfas 896-898
Eutonyl 848a
Eutron 848a

Anderson Surgical Supply Co. 912

Appalachian Hall 927

Ayerst Laboratories
Mediatric 914-915

Ballast Point Manor 912

Bristol Laboratories
Prostaphlin 900-901
Tetrex F. 850

Burroughs-Wellcome Co.
Polysporin 924

Convention Press 912

Dorsey Laboratories
Triaminic 852a

Duvall Home 907

Gebauer Chemical Co.
Ethyl Chloride 913

Geigy Pharmaceuticals
Butazolidin 902-903
Dulcolax 912a
Hygroton 912a

Guild of Prescription Opticians 924a

Highland Hospital, Inc. 926

Hill Crest Hospital 924

Hynson, Westcott & Dunning, Inc.
Lactinex 847

Lakeside Laboratories, Inc.
Inferon 860
Mercuhydrin 924a
Norpramin 889

Lederle Laboratories
Aristocort 853
Declomycin 930a
Stresscaps 864a
Tine Test 927

Eli Lilly & Co.
Ilosone 888a
Tes-Tape 868
Tuinal 924a
V-Cillin K 920a

Medical Supply Co. 895

National Drug Co.
Quinamm 888a

Parke-Davis & Co.
Dilantin Second Cover

Philips Roxane Laboratories
Geroniazol T T 855

Pitman-Moore Co.
Novahistine LP 891

P. L. Dodge Memorial Hospital 926

PM of Florida 905

William P. Poythress & Co.
Mudrane 864a
Solfoton 925

A. H. Robins, Inc.
Allbee with C 856a
Ambar 920a
Donnatal 856a

Roche Laboratories
Librium Back Cover
Valium 898-899

Wm. H. Rorer, Inc.
Parepectolin 905

Rystan Company
Chloresium 895

Sandoz
Mellaril 864a

G. D. Searle Co.
Lomotil 888a

Stuart Co.
Mylanta 856

Surgical Supply Co. 926

Syntex Laboratories
Norinyl 861-864

Tucker Hospital, Inc. 907

S. J. Tutag
Cydril 925

Winthrop Laboratories
Talwin 864a

Wyeth Laboratories
Equagesic 910-911
Equanil 866-867
PenVee K 851

Wynn Pharmaceuticals, Inc.
Aminophylline Dura-Tabs 848
Numa Dura-Tabs 909

Library
New York Academy of Medicine
2 East 103rd St
New York N Y J 12-67
10029

WHEN ANXIETY IS A SIGNIFICANT COMPONENT OF THE CLINICAL PROFILE

LIBRIUM®
(chlordiazepoxide HCl)

Also available as
LIBRITABS™ (chlordiazepoxide)
5-mg, 10-mg, 25-mg tablets

ROCHE

L 153
SE
A
O

Before prescribing, please consult complete product information, a summary of which follows:

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver-function tests advisable during protracted therapy.

Usual Daily Dosage: Individualize for maximum beneficial effects. *Oral*—Adults: Mild and moderate anxiety and tension, 5 or 10 mg t.i.d. or q.i.d.; severe states, 20 or 25 mg t.i.d. or q.i.d. Geriatric patients: 5 mg b.i.d. to q.i.d. (See Precautions.)

Supplied: Librium® (chlordiazepoxide HCl) Capsules, 5 mg, 10 mg and 25 mg—bottles of 50. Libritabs™ (chlordiazepoxide) Tablets, 5 mg, 10 mg and 25 mg—bottles of 100. With respect to clinical activity, capsules and tablets are indistinguishable.

Roche Laboratories • Division of Hoffmann-La Roche Inc • Nutley, N.J. 07110

OCTOBER, 1967
Volume 54
Number 10

The JOURNAL of the Florida Medical Association

Symposium on Back Problems



OFFICIAL PUBLICATION
OF THE
FLORIDA
MEDICAL ASSOCIATION

Dilantin®
(diphenylhydantoin)

PARKE-DAVIS

In untold thousands of epileptic patients... Dilantin has been, and continues to be, the bedrock of therapy.

DILANTIN is useful in the treatment of grand mal epilepsy and certain other convulsive states. Its use will prevent or greatly reduce the incidence and severity of convulsive seizures in a substantial percentage of epileptic patients, without the hypnotic and narcotizing effects of many anticonvulsant drugs.
PRECAUTIONS: Periodic examination of the blood is advisable. Nystagmus in combination with diplopia and ataxia indicates dosage should be reduced. The possibility of toxic effects during pregnancy has not been explored. ADVERSE REACTIONS: Allergic phenomena such as polyarthropathy, fever, skin eruptions, and acute generalized morbilliform eruptions with or without fever. Rarely, dermatitis goes on to exfoliation with hepatitis, and further dosage is contraindicated. Gingival hypertrophy, hirsutism, and excessive motor activity are occasionally encountered. During initial treatment, side effects may include gastric distress, nausea, weight loss, nervousness, sleeplessness, feeling of unsteadiness. Macrocytosis, megaloblastic anemia, leukopenia, granulocytopenia, thrombocytopenia, pancytopenia, agranulocytosis, and aplastic anemia have been reported. Nystagmus, lymphadenopathy, lupus erythematosus, erythema multiforme (Stevens-Johnson syndrome), and a syndrome resembling infectious mononucleosis with jaundice have occurred.
DILANTIN is supplied in several forms including Kapseals® containing 0.1 Gm. and 0.03 Gm. diphenylhydantoin sodium.
Parke, Davis & Company, Detroit, Michigan 48232

The color combinations of the banded capsules are Parke-Davis trademarks. The orange-banded white capsule identifies Parke-Davis 0.1 Gm. diphenylhydantoin sodium; the pink-banded white capsule 0.03 Gm. diphenylhydantoin sodium.

PARKE-DAVIS 015R67

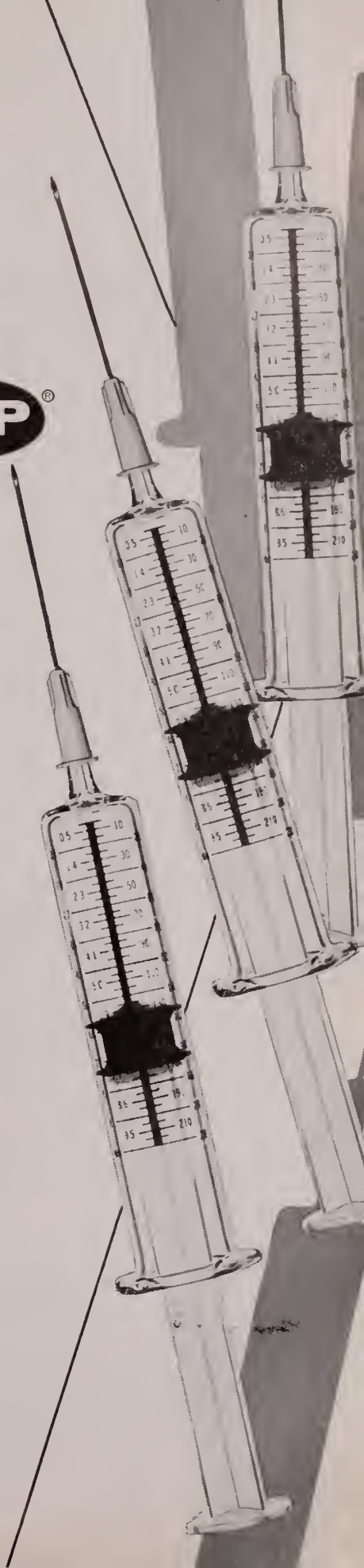


BSP® DISPOSABLE UNIT

HW&D BRAND OF SODIUM SULFOBROMOPHTHALEIN INJECTION, USP

(50 mg. per ml.)

BSP®



BROMSULPHALEIN®

IN A COMPLETE,

STERILE,

DISPOSABLE,

& ECONOMICAL

PATIENT-UNIT.

BSP, one of the more valuable single laboratory procedures for determining hepatic function, is now packaged in a complete individual patient-unit.

Each BSP Disposable Unit contains a sterile syringe with the 5 mg./kg. BSP dosage schedule imprinted on the barrel, a sterile needle, alcohol swab and a 7.5 ml. or 10 ml. size ampule of terminally sterilized Bromsulphalein solution.

This all-inclusive disposable put-up lessens the chance of cross-infection and saves time and labor— the most costly commodities.

HYNSON, WESTCOTT & DUNNING, INC.

(BSPD3)

BALTIMORE, MARYLAND 21201



following infection

B and C vitamins are therapy: STRESSCAPS B and C vitamins in thei peutic amounts...help the body mobilize defenses during convalescence...a response to primary therapy. The patient with a severe infection, and mai others undergoing physiologic stress, may benefit from STRESSCAPS capsul



Stresscaps®

Stress Formula Vitamins Lederle

FOR PROFESSIONAL RECOMMENDATION ONLY

Each capsule contains:

Vitamin B_1 (as Thiamine Mononitrate)	10 mg
Vitamin B_2 (Riboflavin)	10 mg
Vitamin B_6 (Pyridoxine HCl)	2 mg
Vitamin B_{12} Crystalline	4 mcgm
Vitamin C (Ascorbic Acid)	300 mg
Niacinamide	100 mg
Calcium Pantothenate	20 mg

Recommended intake: Adults, 1 capsule daily, for the treatment of vitamin deficiencies. Supplied in decorative "reminder" jars of 30 and 100; bottles of 500.

LEDERLE LABORATORIES, A Division of American Cyanamid Company, Pearl River, New York

Leder

626-6-3

The JOURNAL
of the Florida Medical Association

Volume 54, Number 10, October 1967

THIS ISSUE

Scientific Section

Symposium on Back Problems

Introduction, Thad Moseley, M.D. 955
Adult Postural Back Pain, Charles A. Mead Jr., M.D. 956
Back Disorders in Children, Robert P. Keiser, M.D. 958
Spine Fractures Involving the Trunk, Davis S. Boling, M.D. 960
Disability Evaluation of the Back, Wendell J. Newcomb, M.D. 962
Decisions of Care in Back Operations, Wallace E. Miller, M.D. 964
Treatment of Acute Lumbosacral Strain, Robert J. Pfaff, M.D. 968
Osteoporosis in the Aged Spine, James L. West, M.D. 972

Special Articles

So You Want to Write an Article, James O. Bond, M.D. and Wilson T. Sowder, M.D. 979
A Rubeolad Classic, Thomas Collins, M.D. 988
'By the Numbers' Receipted Bill System, Robert E. Raborn, M.D., Allyn F. Judd, M.D. and Donald E. Bebout, M.D. 997

Editorials

Observations on Financing Medical Care, H. Phillip Hampton, M.D. 976
Medicine and Religion, Harry E. Beller, M.D. 977

Departments

President's Page 938
The Medical Detective 940
News 941
Government News 951
50 Years Ago in the Journal 1006
Association News 1010
Deaths 1018
Classified 1020

Miscellaneous

Meetings 986
National and Regional Meetings in Florida 1014
Florida Medical Association Officers and Council Chairmen 1022
Information for Authors 1022
Index to Advertisers 1023

THAD MOSELEY, M.D.
Editor

Assistant Editors

JOHN M. PACKARD, M.D.
OSCAR W. FREEMAN, M.D.

Assistant Editor from the Board of Governors
JACK Q. CLEVELAND, M.D.

W. HAROLD PARHAM
Managing Editor

EUGENE L. NIXON
Associate Managing Editor

LOUISE RADER
Assistant Managing Editor

EDITH B. HILL
Editorial Consultant

lished monthly at Jacksonville, ida. Price $7.00 a year, single num- 70 cents. Address Journal of ida Medical Association, P.O. Box 735 Riverside Ave., Jacksonville, 32203. Telephone (904) 356-1571. Ac- ted for mailing at special rate of age provided for in Section 1103, of Congress of October 3, 1917; horized October 16, 1918. Entered second class matter under Act of gress of March 3, 1879, at the post ce at Jacksonville, Florida, October 1924. Available on microfilm begin- g with the 1967 volume. Address uiries to University Microfilms, 300 th Zeeb Road, Ann Arbor, Michi- 48106.

Owned and published by the Florida Medical Association, Inc. The Journal is not responsible for the opinions and statements of its contributors.



President's Page

Nursing Shortage

Everyone in and many people out of the medical profession realize that there is today a marked shortage of nurses, particularly in hospitals. Every indication is that the situation will become much more acute before there is any improvement.

Many reasons exist for the shortage, and it may be worthwhile to point out a few. In World War II women found a place for themselves in industry where wages were good. Registered nurses, like most hospital employees, had been underpaid for years (though there has been a belated tendency to correct this inequity) and consequently, girls who were interested in income rather than service tended to enter industrial work with higher pay.

The cost of running diploma schools, the traditional training ground of the R.N., has been rising rapidly and, as a result, many hospitals discontinued training schools for reasons of economic necessity. Other factors have contributed to the closing of these schools. In 1910, the first baccalaureate program for nurses was instituted at the University of Minnesota. Since then there has been a gradual increase in the number of degree schools, with a tendency to downgrade diploma schools. The situation was compounded by the American Nurses Association position paper in 1965 which recommended that education for professional nursing practice should take place in a baccalaureate setting, and that education for technical nursing practice should take place in two year Associate Degree programs. To put frosting on the cake, the New York State Nurses Association publication "Blueprints for the Education of Nurses" in December 1966 recommended that no new hospital diploma programs and no new programs for practical nurses be established after January 1, 1967, and that all programs for professional nurse education be transferred to institutions of higher learning by 1972; this at a time when the shortage of nurses of all kinds was already recognized as critical. One of the unfortunate byproducts of this "little gem" is that high school counselors are de-emphasizing diploma schools of nursing to their students.

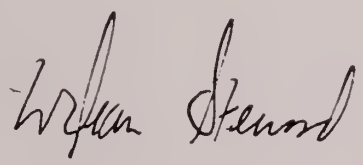
What about the situation in Florida? The 1967 Survey of Health Occupations in the State of Florida reveals that there are now 9,100 registered nurses and 4,200 licensed practical nurses actively working, and there are currently vacancies for 1,203 R.N.s and 769 L.P.N.s. The estimated need for the next two years is for 4,948 R.N.s and 2,726 L.P.N.s.

Where will they come from? Graduates from the five baccalaureate (4 year) nursing schools in Florida during the past 10 years have ranged from 57 to 198, with 168 graduated in 1966. Associate Degree (2 year) graduates varied from 26 in 1958 to 294 in 1966 with the number of schools climbing from none in 1956 to 15 in 1966. Diploma school graduates have ranged from 191 to 252 in the last 10 years, and 220 were graduated in 1966. During this 10 year period, nine of the diploma schools have closed, leaving only five still active in the state. The estimated capacity of the three types of schools is 1,050 graduates yearly, but graduates totaled 682 in 1966. L.P.N. graduates have risen from 308 to 704 in the past 10 years, and schools giving this training have increased from 13 in 1956 to 25 in 1966.

These statistics make it obvious that even with an extensive recruitment plan, Florida will not have enough new graduates within the next few years, and possibly not within the next 10 years, to fill its nursing shortage. There is one additional source, however, which has been neglected.

An estimated 10,000 to 15,000 trained nurses in the state are not employed for one reason or another. Many of these could be brought up to date in their training with a six week refresher course. This should be a continuing program, and not just a temporary one. Efforts should be made to arrange part time work schedules, and possibly nursery schools should be made available for small children where indicated. Diploma schools should be encouraged to increase their enrollments, and possibly should have some assistance from state or county educational funds to meet their deficits. Schools of practical nursing should be increased in number and in enrollment, as this approach will most rapidly help meet current needs for patient care while expansion is carried out in the more advanced schools.

The problem is a grave one, but it can be overcome if the medical profession of Florida will give cooperation and encouragement to hospital administrators, educational institutions, vocational programs and last, but not least, to the high school students who are potential nurses. In the latter instance, much help can be obtained from that wonderful group of women who compose the Auxiliary of the Association.





The Medical Detective

Rapture of the Deep

The underwater environment is rapidly becoming increasingly popular in Florida, but there has been little regulation of the breathing equipment, and adequate education of the users of this equipment has been lacking. The underwater pleasure seeker may use several techniques including simple breath holding and shallow diving with or without a face mask and snorkel device, or he may utilize a scuba tank which allows comparatively free rein on his activities.

One such underwater devotee was a 36-year-old man who was visiting one of Florida's springs with his fellow salesmen during an annual company sales meeting. The group was sunning after a night of heavy partying and someone suggested a swim. The salesman had a considerable hangover and apparently thought that a swim would be good therapy. He swam about 50 yards to a raft with his friends and rested. A pair of teenagers were scuba diving nearby and swam to the raft to adjust their equipment. The group got into conversation and within a few minutes the salesman asked to borrow the equipment to show his friends how he could use it.

Ten minutes after the salesman had submerged wearing the borrowed apparatus, the group became concerned about their friend and the teenager with the scuba outfit went in search of him. The teenager surfaced after several minutes and shouted that he could not find the diver and wanted help. The sheriff's department responded with several volunteer divers and the search was on. The body was recovered several hours later. It had become entangled in weeds in 20 feet of water less than 50 yards from the raft. The local medical examiner was called to the scene and ordered the body brought to the local hospital for autopsy. The scuba tank and equipment were checked and the tank was found to be almost empty. The mouthpiece was out of the diver's mouth when his body was recovered.

The autopsy revealed 120 mg./100 ml. of blood alcohol; evidence of drowning included foreign matter in the bronchi identified as parts of weeds, mud and vomitus. The lungs were edematous and there was some hemorrhage in the inner ear. Blood was removed from the right and left chambers of the heart and there was an elevation of the chloride level in the right side over that of the left side.

This case is not an unusual one. Most scuba deaths are related to panic in minor emergencies and improper use or maintenance of equipment; many also are related to alcohol consumption and lack of experience. The deceased learned what he knew of scuba diving several years before at the YMCA pool in his home town. He used extremely poor judgment by utilizing borrowed equipment in a totally unfamiliar area without the accompaniment of a companion. Apparently he panicked when caught in the weeds and then lost consciousness and drowned when the oxygen pressure diminished. The alcohol factor affects susceptibility to hypoxia with subsequent impairment of coordination of muscular activity; decrease of both depth and color perception results.

Other cases of scuba deaths have involved air emboli, nitrogen narcosis, carbon monoxide intoxication, coronary artery disease, shark attacks and coral and wave action injuries.

I would like to emphasize the need for us as doctors to stimulate interest regarding safety in the underwater environment and more education of those who would take this up as a hobby.

WILLIAM G. ECKERT, M.D.

NEWS

Telegram Autopsy Consent Now Authorized

The recently passed Florida Autopsy Consent Law, which went into effect July 1, 1967, provides that a telegram may be accepted as written consent if sent by the spouse, nearest relative or, if no such next of kin can be found, the person who has assumed custody of a body for burial.

The new law, however, does not provide for telephone consent, monitored or otherwise. Telephone consent alone does not conform to Florida law; consent for autopsy must be written.

In cases of consent by telegram, the law states: "Any such written consent may be given by telegram, and any telegram purporting to have been sent by a person authorized to give such consent will be presumed to have been sent by such a person."

The law also states that "if after diligent search and inquiry" no person can be found who can authorize an autopsy, the autopsy may be performed after a reasonable time. A reasonable time is defined as not less than 48 hours or more than 72 hours after death.

Wyeth Pediatric Fellowships Available

Applications for two year Wyeth Pediatric Fellowships are available now for residencies commencing July 1, 1968.

Sponsored by the Wyeth Fund for Postgraduate Medical Education, each of these fellowships provides $4,800 over two years toward the advanced training required for board certification in pediatrics. Wyeth's monthly payments, made directly to recipients, are in addition to the usual stipends paid to residents by the institutions in which they train.

Eligible to apply are interns, physicians who have recently completed an internship, research Fellows or physicians completing their tour of duty with the Armed Services or the U.S. Public Health Service. Applicants must be citizens of the United States or Canada. Those who have already started pediatric residency training are not eligible.

Each Fellow may choose the hospital in which he will train provided that it is accredited by the residency review committee which represents the American Board of Pediatrics, the American Academy of Pediatrics and the Council of Medical Education and Hospitals of the American Medical Association.

Fellowship applications must be submitted by Dec. 1, 1967. For further information contact Philip S. Barba, M.D., chairman, Wyeth Fellowship Selection Committee, 120 Erdenheim Road, Philadelphia, Pa. 19118.

FMA Journal Microfilm Edition Now Available

The Journal of the Florida Medical Association will be available on microfilm, annually, beginning with the 1967 volume. Sales of the microfilm editions will be restricted to subscribers of the paper edition and will be distributed at the end of the calendar year.

Inquiries concerning the microfilm edition of the Journal should be addressed to University Microfilms, 300 North Zeeb Road, Ann Arbor, Michigan 48106.

Nationwide Blood Coverage Provided

A new agreement covering the nationwide exchange of blood and blood credits between the country's major blood banking organizations has been announced jointly by the American National Red Cross (ARC) and the American Association of Blood Banks (AABB).

The agreement, signed by General James F. Collins, president of the ARC, and Dr. George Hummer, president of the AABB, replaces the original agreement which the two organizations developed in 1961, setting up a national reciprocal system to facilitate blood donor replacements and to utilize blood supplies more effectively.

Workers Hired *Because* Of Handicap

A blind electrician who installs electrical outlets in tract houses, a retarded kitchen worker who supervises "normal" employees and a cerebral palsy victim who is an electronics genius comprise a cross section of millions of handicapped Americans who are not handicapped on the job.

While more and more employers are hiring the handicapped in spite of their disabilities, some hire workers *because* of their handicaps. For instance, the Glidden Company, a chemical firm in Florida, employs the blind to judge taste and odor of synthetic flavoring and perfume chemicals, finding them four times more effective than sighted workers.

One of the country's leading candy manufacturers considers employment of the mentally retarded a wise investment. The company reports these employees have a fine attendance record and better-than-average safety record. As a general rule, retarded workers have much greater tolerance for repetitive, short cycle tasks than normal workers.

Hiring the handicapped does not cause a company's insurance rates to rise. Rates are based upon the type of work in which a company is engaged and its individual accident experience. Generally speaking, handicapped workers have fewer accidents than ordinary workers.

Oral Biology Division Organized At UM

A Division of Oral Biology is being organized at the University of Miami, reflecting the expanding importance and scope of its current dental research program, according to Dr. Hayden C. Nicholson, vice president for medical affairs and dean of the UM School of Medicine.

The dental research program at UM has been functioning for a number of years, and has been steadily widening its efforts and winning national recognition under the direction of Dr. Doran D. Zinner, assistant professor of microbiology.

At present its research work is supported by grants totaling more than $1 million.

UF Awarded PHS Grant

The University of Florida has been awarded a general purpose training grant of $82,078 from the Public Health Service for bioenvironmental engineering.

Funds are one year's allotment of a five-year continuing grant for training graduate students, purchasing equipment and for faculty salaries, according to Dr. John E. Kiker Jr., chairman of the university's Department of Bioenvironmental Engineering.

The award brings to six the number of bioenvironmental training grants currently in effect at the university, supporting projects in air pollution, radiological health, water supply and pollution control and solid wastes.

UF Human Development Center Dedicated

Four outstanding authorities in the areas of human development and mental health spoke at dedication ceremonies of the University of Florida's Human Development Center April 15.

The event brought to the campus and the J. Hillis Miller Health Center Dr. Peter F. Regan III, executive vice president, State University of New York at Buffalo, and former chairman, Department of Psychiatry in the University's College of Medicine; Dr. Arthur J. Lesser, deputy chief, Children's Bureau, Department of Health, Education and Welfare, Washington, D.C.; Dr. Lewis Thomas, dean, College of Medicine, New York University, and Dr. Albert J. Solnit, professor of pediatrics and psychiatry, Yale University School of Medicine.

Two of these scientists lectured at a scientific session which began at 2 p.m. Dr. Solnit discussed "Behavior in Man," and Dean Thomas spoke on "Perspectives in Human Biology."

Internists To Meet

The Florida Society of Internal Medicine will hold its First Annual Socioeconomic Workshop at the Doral Country Club, Miami, on November 10 and 11.

The workshop committee has purchased 40 tickets on the 40-yard line for the Miami vs. Georgia Tech football game. For registration and ticket information, contact Robert V. Edwards, M.D., 1554 Venera Avenue, Coral Gables 33146.



let's be specific about Campbell's Soups... and *reducing diets*



There are more than 30 million people in America who are overweight. During the next year, you probably will see more than 1,000 of them in your own practice.

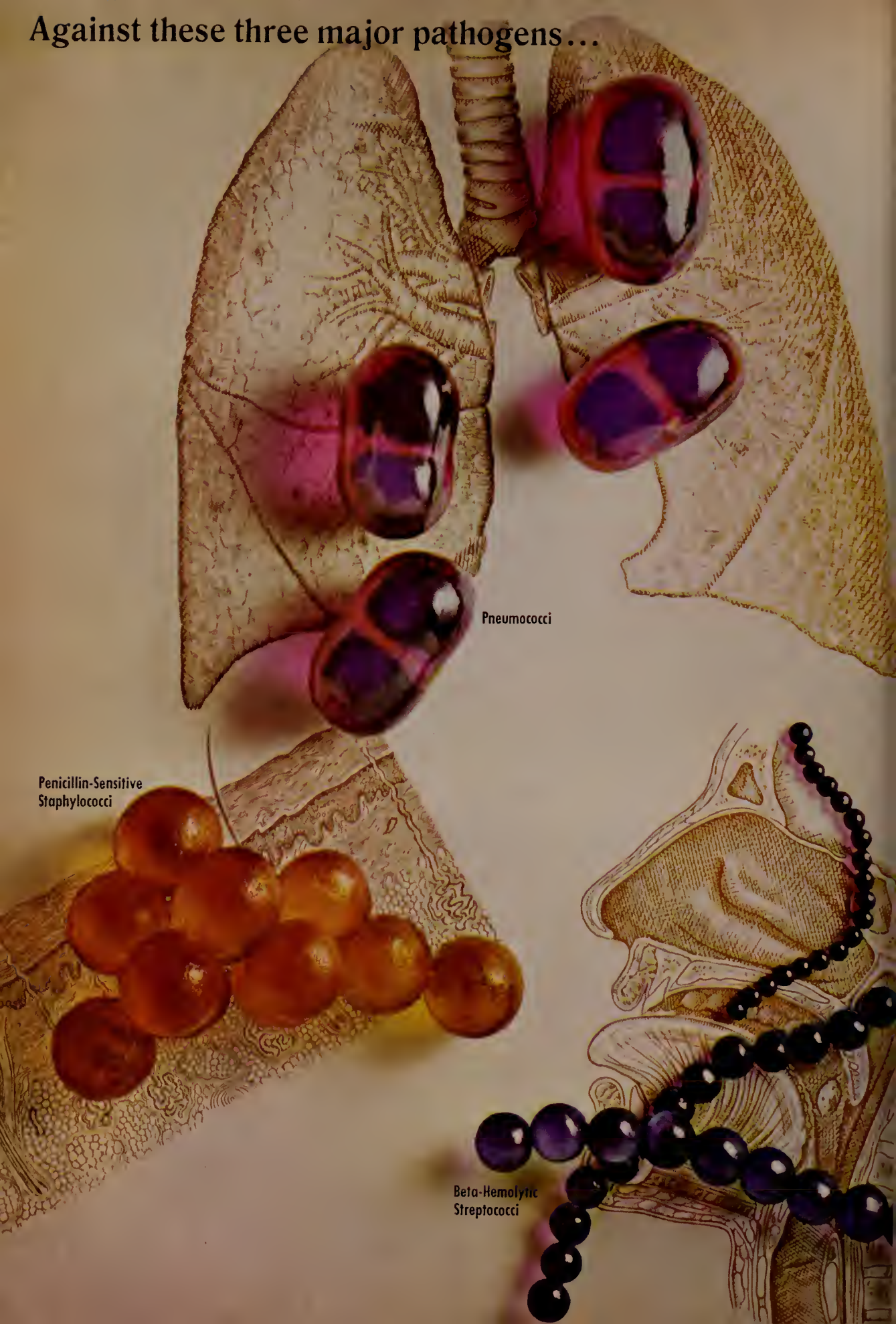
One good way to help these patients is to give them a reducing diet based on ordinary eating patterns.

Campbell has prepared a sensible plan for weight control based on ordinary eating patterns. The plan consists of a patient instruction booklet and a set of menus which provide approximately 1,200 calories daily. The menus are balanced to provide the minimum daily requirements of nutrients.



To obtain a supply for your office write to:
Campbell Soup Company, Box 265, Camden, N. J. 08101

Against these three major pathogens...



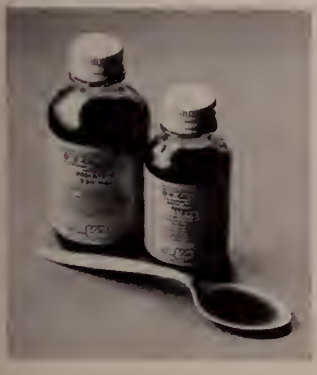
V-Cillin K® provides dependable oral antibacterial therapy

because it combines a high degree of activity...

V-Cillin K has been shown to be effective in the treatment of streptococcus and pneumococcus infections as well as infections caused by sensitive strains of staphylococci. It may be used for the prophylaxis of streptococcus infections in patients with a history of rheumatic fever and for the prevention of bacterial endocarditis after tonsillectomy in patients with a history of rheumatic fever or congenital heart disease.

with high blood levels, even when taken with food

V-Cillin K is stable in acid and immediately soluble. High serum levels, therefore, are reached rapidly. Because it is acid stable, V-Cillin K is well absorbed even when taken close to mealtime. These desirable properties help make V-Cillin K a dependable penicillin for oral use.



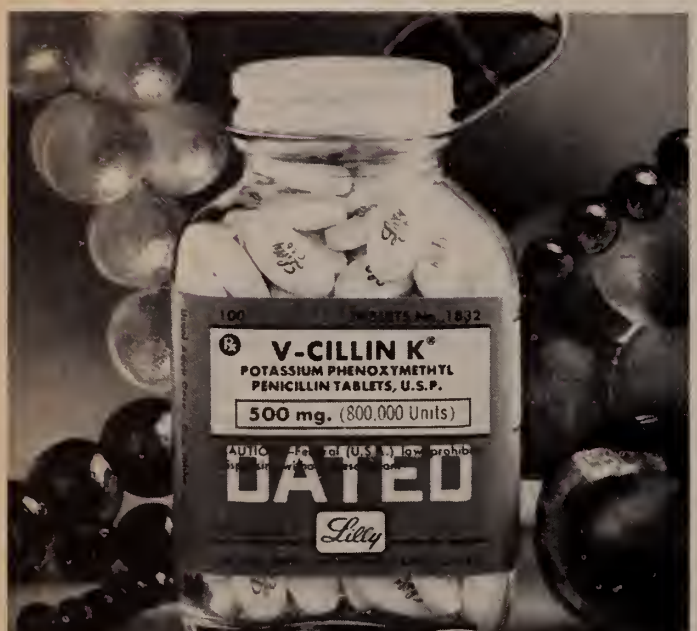
V-Cillin K® Lilly 701297

Potassium Phenoxymethyl Penicillin

Now available: V-Cillin K®, Pediatric, for Oral Solution, 250 mg. (400,000 units) per 5 cc. of solution.

(See next page for prescribing information

New 500 mg. tablets... a more convenient way to give high doses



Description: V-Cillin K is the potassium salt of V-Cillin® (phenoxymethyl penicillin, Lilly). This chemically improved form combines acid stability with immediate solubility and rapid absorption. Higher serum levels are obtained more rapidly with this penicillin than with equal oral doses of penicillin G. The higher serum levels and acid stability of V-Cillin K make it a more dependable penicillin for oral use.

V-Cillin K, Pediatric, is an oral solution of clinically proved V-Cillin K in teaspoon dosage form. When mixed as directed, each 5 cc. (approximately one teaspoonful) will contain 125 mg. (200,000 units) phenoxymethyl penicillin as the potassium salt.

Indications: V-Cillin K has been shown to be effective in the treatment of streptococcus, pneumococcus, and gonococcus infections as well as infections caused by sensitive strains of staphylococci. It may be used for the prophylaxis of streptococcus infections in patients with a history of rheumatic fever and for the prevention of bacterial endocarditis after tonsillectomy and tooth extraction in those patients with a history of rheumatic fever or congenital heart disease.

Contraindication: V-Cillin K should not be administered to a patient with a history of penicillin hypersensitivity.

Warnings: In rare instances, the use of penicillin may cause acute anaphylaxis which may prove fatal unless promptly controlled. This type of reaction appears more frequently in patients with a history of sensitivity reactions to penicillin and in those with bronchial asthma or other allergies. Resuscitative drugs should be readily available for emergency administration. These include epinephrine and pressor drugs (as well as oxygen for inhalation) for relief of immediate allergic manifestations and antihistamines and corticosteroids for delayed effects.

Precautions: V-Cillin K should be used cautiously, if at all, in a patient with a strongly positive history of allergy.

In prolonged therapy with penicillin, and particularly with h parenteral dosage schedules, frequent evaluation of the renal c hematopoietic systems is recommended.

In suspected staphylococcus infections, proper laboratory stud (including sensitivity tests) should be performed.

The use of penicillin may be associated with the overgrowth pencillin-insensitive organisms. In such cases, its administration sho be discontinued, and appropriate measures should be taken.

Adverse Reactions: Although serious allergic reactions are much l common with administration of oral penicillin than with intramuscu forms, manifestations of penicillin allergy may occur.

Penicillin is a substance of low toxicity, but it does possess a sign cant index of sensitization. The following hypersensitivity reactio associated with the use of penicillin have been reported: skin ras ranging from maculopapular eruptions to exfoliative dermatitis; u caria; and reactions resembling serum sickness, including chills, fe edema, arthralgia, and prostration. Severe and often fatal anaphylc has occurred (see Warnings). Hemolytic anemia, leukopenia, thro bocytopenia, and nephropathy are rarely observed side-effects c are usually associated with high parenteral dosage.

Administration and Dosage: For Tablets V-Cillin K and for V-Cillin Pediatric, the usual dosage ranges from 125 mg. (200,000 units) th times a day to 500 mg. (800,000 units) every four hours. For infa the daily dosage may be 50 mg. per Kg. of body weight divided three doses.

Beta-hemolytic streptococcus infections without associated b teremia may be treated with 200,000 to 400,0000 units three time day. Therapy should be continued for a minimum of ten days to prev development of rheumatic fever and/or other serious complicatio Dosage for routine streptococcus prophylaxis in patients with a hist of rheumatic fever or congenital heart disease may be 200,000 u once or twice daily. When such patients undergo tonsillectomy, to extraction, or other minor surgery, the prophylactic dose should 500,000 units every six hours given two days prior to surgery and two days postoperatively. If oral medication is not feasible on the c of surgery, parenteral therapy should be considered. Mild to moc ately severe pneumococcus pneumonia has been treated effectiv with 250 mg. every six hours.

In staphylococcus infections, 400,000 units or more should be gi every six to eight hours in conjunction with indicated surgical pro dures.

For gonorrhea in males, 500 mg. (800,000 units) every four hours three doses may be employed; in females, 500 mg. every four ho for six doses are recommended. Refractory infections generally respc to a second treatment three to four days following completion of first. Treatment of gonorrhea with severe complications should individualized, with prolonged and intensive treatment. Patients wit suspected lesion of syphilis should have a dark-field examination fore receiving penicillin and monthly serologic tests for a minimum three months.

How Supplied: Tablets V-Cillin K, U.S.P., 125 mg. (200,000 units), bottles of 50 and 100; and 250 mg. (400,0000 units) and 500 r (800,000 units), in bottles of 24 and 100.

V-Cillin K, Pediatric, for Oral Solution, 125 mg. (200,000 units) 5 cc. of solution, in 40, 80, and 150-cc.-size packages. [032

Additional information available to physicians upon request. Eli Lilly and Company, Indianapolis, Indiana 46206.

Lilly

701


in an age of discovery
step beyond the
thiazides
announcing
new Lasix®
(furosemide)
See full prescribing info
Photographs courtesy of Jacques-Yves Cousteau, Compagnes Oceanographiques Françaises

an important new agent for the control of diuresis and edema

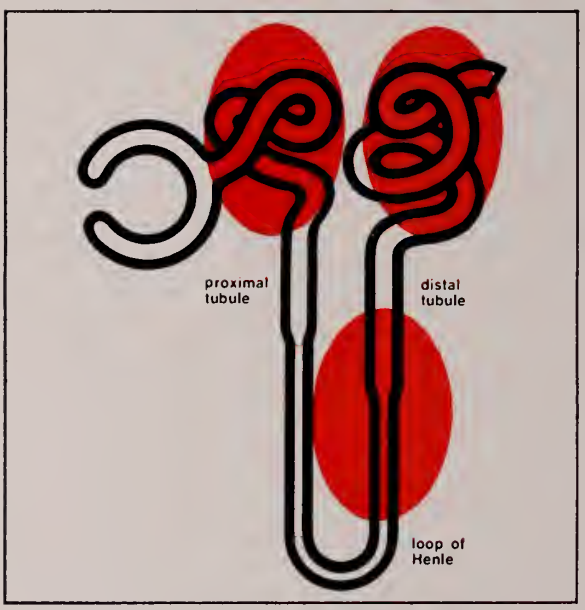
efficacy range

beyond the capacity of any thiazide. In contrast to the thiazides, animal studies indicate that Lasix (furosemide) acts throughout the nephron.[1-3]

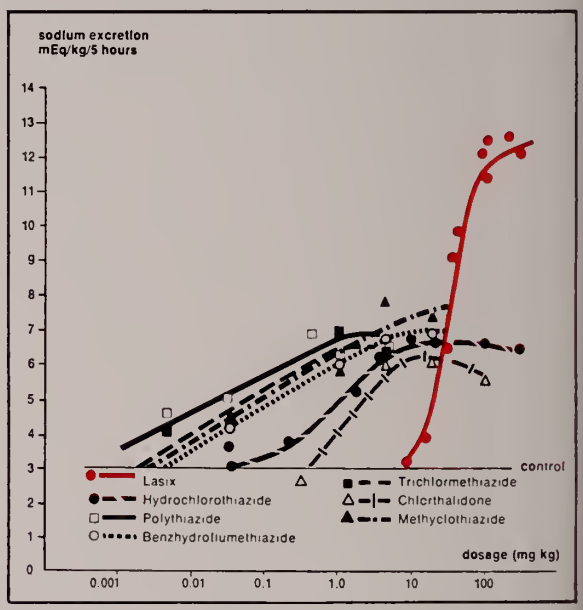
dose-regulated diuresis beyond the ceiling of any thiazide

generally effective in routine cases in low doses (one or two tablets) but, when needed, a vast reserve of measurable diuretic efficacy[4,6] is available merely by increasing dose.[4,7] (Maximum daily dose of 200 mg should not be exceeded. It should be kept in mind that, as with the thiazides, some patients may experience profuse diuresis at lower doses.)

Unlike thiazides, which act in the proximal and distal tubules, animal studies indicate that Lasix (furosemide) acts in the loop of Henle, as well as in the proximal and distal tubules.



The natriuretic action of Lasix (furosemide) in rats compared with that of various other diuretics (adapted from Timmerman, R. J.; Springman, F. R., and Thoms, R. K.[6]).



prompt onset, short duration of action[4,5]

no "round-the-clock" diuresis

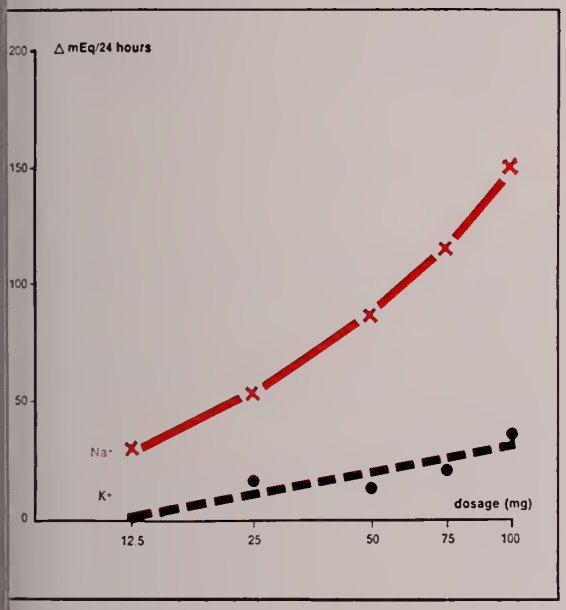
Lasix (furosemide) starts working sooner than thiazides, completes the diuresis faster; spares patients 'round-the-clock "bathroom shuttle". A single dose begins acting within as little as an hour, peak response usually occurs within two hours, and diuretic response is essentially complete in six to eight hours in edematous patients.[4,5]

new Lasix®
(furosemide)

generally achieves a favorable urinary Na/K ratio

Greatly enhanced Na excretion with proportionately less increase in K excretion. (Notwithstanding this ratio, absolute 24-hour potassium excretion may equal that of other diuretics and hypokalemia may occur during treatment with Lasix [furosemide], as with the thiazides.)

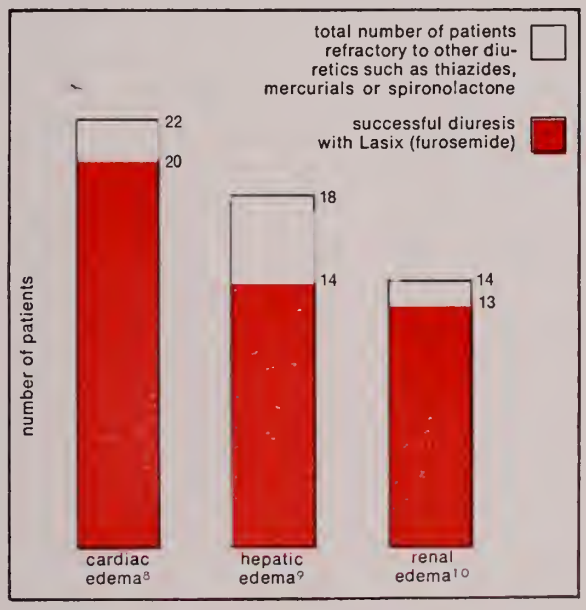
dose-effect curves on sodium and potassium excretion in four normal subjects. Graph shows mean increase in sodium and potassium excretion following oral administration of Lasix (furosemide). (Adapted from Kleinfelder, H.[7])



effective in cardiac[8], hepatic[9], and renal[10] edemas, often including thiazide-refractory cases[8-10]

useful in a wide range of patients, including cases requiring an agent with greater diuretic potential than those commonly employed (In hepatic cirrhosis with ascites, therapy is best initiated in the hospital.)

Response to Lasix (furosemide) in patients refractory to other diuretics: results from three studies.[8-10]



See full prescribing information on next page...

R67

HOECHST PHARMACEUTICAL CO.

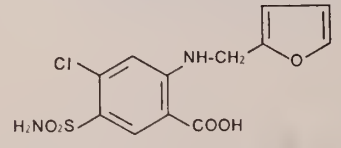
Lasix®

brand of furosemide

WARNING—Lasix (furosemide) is a new, potent diuretic, which if given in excessive amounts can lead to a profound diuresis with water and electrolyte depletion. Therefore, careful medical supervision is required and dose and dose schedule have to be adjusted to the individual patient's needs. (See under "Dosage and Administration.")

Lasix (furosemide) is a new diuretic, chemically distinct from the organomercurials, thiazides and other heterocyclic compounds. It is characterized by: a high degree of efficacy; a rapid onset of action; a comparatively short duration of action; a ratio of minimum to maximum effective dose higher than 1:10; the fact that it acts not only at the proximal and distal tubule but also at the ascending limb of Henle's loop.

Chemistry—Lasix (furosemide) is an anthranilic acid derivative. Chemically, it is 4-chloro-N-furfuryl-5-sulfamoylanthranilic acid. The structural formula is as follows:



Indications—Lasix (furosemide) is indicated for the treatment of edema associated with congestive heart failure, cirrhosis of the liver, and renal disease, including the nephrotic syndrome. Lasix (furosemide) is particularly useful when an agent with greater diuretic potential than those commonly employed is desired. Until further clinical experience is accumulated, Lasix (furosemide) is not recommended for use in hypertension.

Contraindications—Lasix (furosemide) is contraindicated in anuria. If increasing azotemia and oliguria occur during treatment of severe progressive renal disease the drug should be discontinued. In hepatic coma and in states of electrolyte depletion, therapy should not be instituted until the basic condition is improved or corrected. Lasix (furosemide) is contraindicated in patients with a history of hypersensitivity to this compound. Until further experience in children is accumulated, therapy with Lasix (furosemide) should be avoided.

Supplementary Warnings—Excessive diuresis may result in dehydration and reduction in blood volume, with circulatory collapse and with the possibility of vascular thrombosis and embolism particularly in elderly patients. Excessive loss of potassium in patients receiving digitalis glycosides may precipitate digitalis toxicity. Care should also be exercised in patients receiving potassium depleting steroids. Frequent serum electrolyte, CO_2 and BUN determinations should be performed during the first few months of therapy and periodically thereafter and abnormalities corrected or the drug temporarily withdrawn. **In patients with hepatic cirrhosis and ascites initiation of therapy with Lasix (furosemide) is best carried out in the hospital.** Sudden alterations of fluid and electrolyte balance in patients with cirrhosis may precipitate hepatic coma; therefore, strict observation is necessary during the period of diuresis. Supplemental potassium chloride and, if required, an aldosterone antagonist are helpful in preventing hypokalemia and metabolic alkalosis. As with any new drug, patients should be observed regularly for the possible occurrence of blood dyscrasias, liver damage, or other idiosyncratic reactions.

In those instances where potassium supplementation is required, coated potassium tablets should be used only when adequate dietary supplementation is not practical. There have been several reports, published and unpublished, concerning nonspecific small bowel lesions consisting of stenosis with or without ulceration, associated with the administration of enteric-coated thiazides with potassium salts. These lesions may occur with enteric-coated potassium tablets alone or when they are used with nonenteric-coated thiazides, or certain other oral diuretics. These small bowel lesions have caused obstruction, hemorrhage, and perforation. Surgery was frequently required, and deaths have occurred. Based on a large survey of physicians and hospitals, both American and foreign, the incidence of these lesions is low, and a causal relationship in man has not been definitely established. Available information tends to implicate enteric-coated potassium salts although lesions of this type also occur spontaneously. Therefore, coated potassium-containing formulations should be administered only when indicated, and should be discontinued immediately if abdominal pain, distention, nausea, vomiting, or gastrointestinal bleeding occur.

Usage in Pregnancy—The use of any drug in pregnancy, lactation or in the childbearing age group requires that the potential benefits of the drug be weighed against possible hazards to the mother and child. Reproduction studies with Lasix (furosemide) in mice, rabbits, and rats have produced no evidence of drug-induced fetal abnormalities. However, Lasix (furosemide) has had only limited use in pregnant patients.

Precautions—As with any potent diuretic, electrolyte depletion may occur during therapy with Lasix (furosemide), especially in patients receiving higher doses and a restricted salt intake. Electrolyte depletion may manifest itself by weakness, dizziness, lethargy, leg cramps, anorexia, vomiting, and/or mental confusion. In edematous hypertensive patients being treated with antihypertensive agents, care should be taken to reduce the dose of these drugs when Lasix (furosemide) is administered, since Lasix (furosemide) potentiates the hypotensive effect of antihypertensive medications. Asymptomatic hyperuricemia can occur and gout may rarely be precipitated. Reversible elevations of BUN may be seen. These have been observed in association with dehydration which should be avoided, particularly in patients with renal insufficiency. Although no pronounced effect on carbohydrate metabolism has been demonstrated, periodic checks on urine and blood glucose should be made in diabetic patients receiving Lasix (furosemide). Occasional increases in blood glucose have occurred during therapy with Lasix (furosemide). Sulfonamide diuretics have been reported to decrease arterial responsiveness to pressor amines and to enhance the effect of tubocurarine. Great caution should be exercised in administering curare or derivatives to patients undergoing ther with Lasix (furosemide), and it is advisa to discontinue Lasix (furosemide) for week prior to any elective surgery.

Adverse Reactions—Infrequent skin r pruritus, paresthesia, blurring of vis postural hypotension, nausea, vomiting diarrhea may occur. A single case thrombocytopenia has been reporte which Lasix (furosemide) was conside to be the causative agent. There h been a few instances of leukopenia one report of acute pancreatitis altho relationship to the drug has not been tablished. Lasix (furosemide) induced uresis has occasionally been accompar by weakness, fatigue, lightheadednes dizziness, muscle cramps, thirst, and nary frequency.

Dosage and Administration—The u dose of Lasix (furosemide) is 1 to 2 tab (40 to 80 mg) given as a single dose, p erably in the morning. Ordinarily, a pro diuresis ensues. Depending on the tient's response, a second dose can be ministered 6 to 8 hours later. This dos and dosage schedule can then be m tained or even reduced. If the diuretic sponse with a single dose of 1 to 2 tab (40 to 80 mg) is not satisfactory, e.g., patient with congestive heart failure ref tory to maximal doses of thiazides, the lowing schedule should be used: Incr this dose by increments of 1 tablet (40 not sooner than 6 to 8 hours after the vious dose until the desired diuretic e has been obtained. This individually d mined single dose should then be g once or twice daily (e.g., at 8:00 a.m. 2:00 p.m.). Based on completed studi maximum daily dose of 200 mg shoul be exceeded. Higher doses are curr under investigation. The mobilizatio edema may be most efficiently and s accomplished by utilizing an intermi dosage schedule in which the diuret given for 2 to 4 consecutive days week. With doses exceeding 80 mg and given for prolonged periods, ca clinical and laboratory observations particularly advisable. Until further ex ence in children is accumulated, (furosemide) should not be given to dren.

How Supplied—Lasix (furosemide) is plied as white, monogrammed, sc tablets of 40 mg in amber bottles of

References: (1) Suki, W.; Rector, F. C and Seldin, D. W.: J. Clin. Invest. *44*: 1965. (2) Deetjen, P.: Pflügers Arch. Physiol. *284*:184, 1965. (3) Malnic Vieira, F. L., and Enokibara, H.: N *208*:80, 1965. (4) Hutcheon, D. E.; M D., and Romano, A.: Arch. Int. Med. 542, 1965. (5) Stokes, W., and Nunn, L. Brit. M.J. 2:910, 1964. (6) Timmerman, Springman, F. R., and Thoms, R. K.: Therap. Res. 6:88, 1964. (7) Kleinfelde German M. Month. 8:459, 1963. (8) Pe P.: Acta med. scandinav. *177*:777, (9) Steigmann, F.; Oz, R.; De Will, P. Dubin, A.: Am. J. M. Sc. *252*:436, (10) Muth, R. G.: J.A.M.A. *195*:1066,

HOECHST
PHARMACEUTICAL
Cincinnati, Ohio 45

139R67



one step ahead

Times change and classic lobar pneumonia s rare. Your next pneumonia patient may have n atypical clinical picture and perhaps a athogen in his sputum such as *H. influenzae* r *Mycoplasma pneumoniae* (Eaton Agent), vhich is believed to be responsible for one out f every five cases of pneumonia. That's why it nakes sense to keep one step ahead—and pre- cribe the *true* broad-spectrum antimicrobial ctivity of DECLOMYCIN.

With DECLOMYCIN, you get effective ac- ion against *both H. influenzae* and *Mycoplasma* neumoniae, plus prolonged high levels of anti- iotic activity in the blood and the lung tissue. You're one step ahead with...

DECLOMYCIN®
DEMETHYLCHLORTETRACYCLINE

Lederle

Prescribing information on next page.

For a wide range of everyday infections—respiratory, urinary tract and others—in the young and aged—the acutely or chronically ill.

For common and unusual pneumonias

DECLOMYCIN Demethylchlortetracycline should be equally or more effective therapeutically than other tetracyclines when the offending organisms are tetracycline-sensitive.

Contraindication: History of hypersensitivity to demethylchlortetracycline.

Warning—In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated, and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort. Necessary subsequent courses of treatment with tetracyclines should be carefully observed.

Precautions—Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects—Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes. A rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney—rise in BUN, apparently dose related. Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth — dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs discontinue medication and institute appropriate therapy.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

Capsules: 150 mg; **Tablets:** film coated, 300 mg, 150 mg, and 75 mg of demethylchlortetracycline HCl.

DECLOMYCIN®
DEMETHYLCHLORTETRACYCLINE

LEDERLE LABORATORIES, A Division of
American Cyanamid Company, Pearl River, New York

Lederle

452-7 4953



New view of an oral contraceptive at work

Although suppression of ovulation remains the primary mode of action of oral contraceptives, newer knowledge indicates that products like Norinyl-1—a combination of both low-dosage progestogen and estrogen for the full treatment cycle—may provide multiple action that helps explain their unexcelled record of contraceptive effectiveness. This report explores the possible secondary protective mechanisms offered by combined hormonal administration.

Accumulating evidence has indicated that sparse, highly viscous cervical mucus has a possible adverse effect on the motility and survival of spermatozoa.

The estrogen-opposing progestational ingredient of Norinyl-1 (norethindrone 1 mg. with mestranol 0.05 mg.) changes the usual midcycle picture of a thin, watery cervical mucus. The result—a built-in barrier that appears to inhibit sperm from reaching the ovum should one be released. The inset in the adjoining photograph shows immobile spermatozoa as they appear in cervical mucus taken from a patient treated with Norinyl-1.

See last page for contraindications, precautions, side effects and dosage.

How the estrogen-opposing action of Norinyl-1 creates cervical mucus that may be hostile to sperm penetration

Normally, estrogen activity during the fertile midcycle stimulates the production of a profuse and watery cervical mucus that permits maximum sperm motility and promotes penetration.

But what happens when Norinyl-1 is administered? Its potent progestogen, norethindrone, opposes estrogen stimulation of cervical mucus. Consequently, the amount of mucus decreases and its viscosity increases. This results in a sparse but thick mucus barrier that appears to diminish the vitality of the sperm and to impair its powers of penetration.

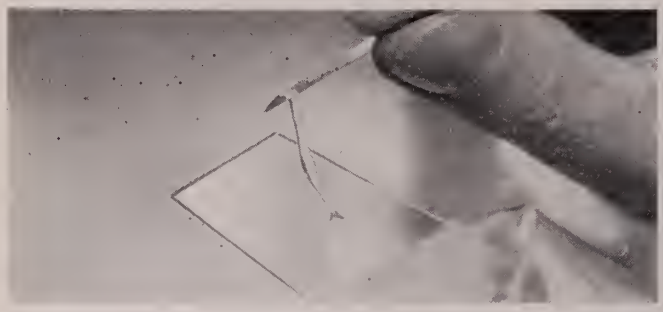
The role of viscous cervical mucus as a secondary action of Norinyl-1

In a report on 89 patients taking this medication,* cervical mucus obtained from cycle day 5 to cycle day 29 appeared scant and thick and exhibited little or no Spinnbarkeit.

In the opinion of this investigator, the effect on cervical mucus may be sufficient to prevent conception.

*Cohen, M. R.: Symposium: Mechanisms of Action of Low Dosage Oral Contraceptive, Yale University Medical Center, New Haven, Conn., April 6, 19

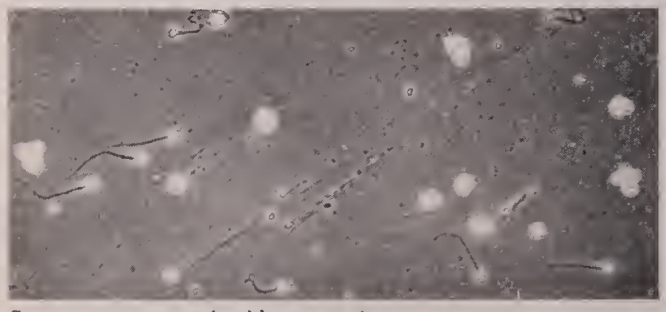
Normal cervical mucus at midcycle in untreated patient is known to permit sperm motility... promote sperm penetration.



Cervical mucus is thin and watery with a stretchability (Spinnbarkeit) of 15 to 20 cm.

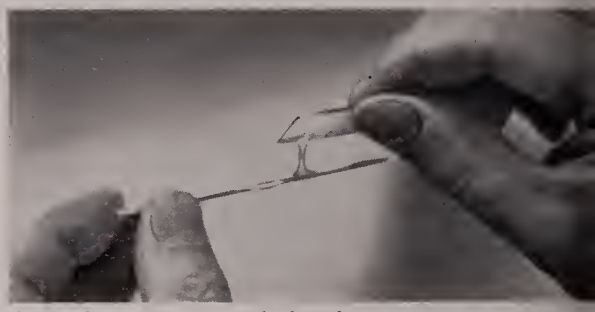


Thin, watery mucus crystallizes into this well-defined, fernlike pattern within a minute.

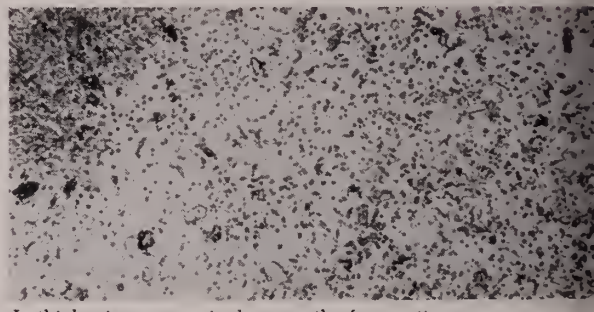


Spermatozoa appear healthy, are active and freemoving.

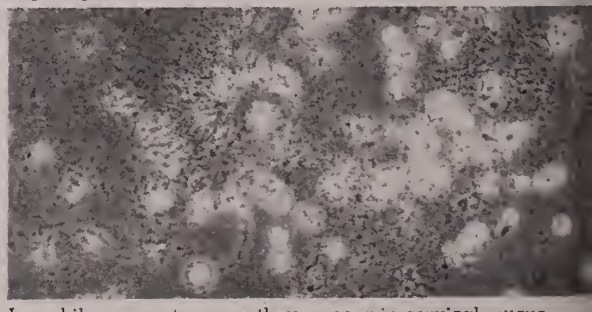
Viscous cervical mucus at midcycle produced by Norinyl-1 appears to impair sperm vitality... inhibit penetration.



Cervical mucus is scanty, thick and viscous. Spinnbarkeit is 1 cm. or less.



In thick, viscous cervical mucus the fern pattern is poorly defined or absent.

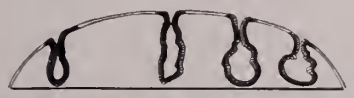


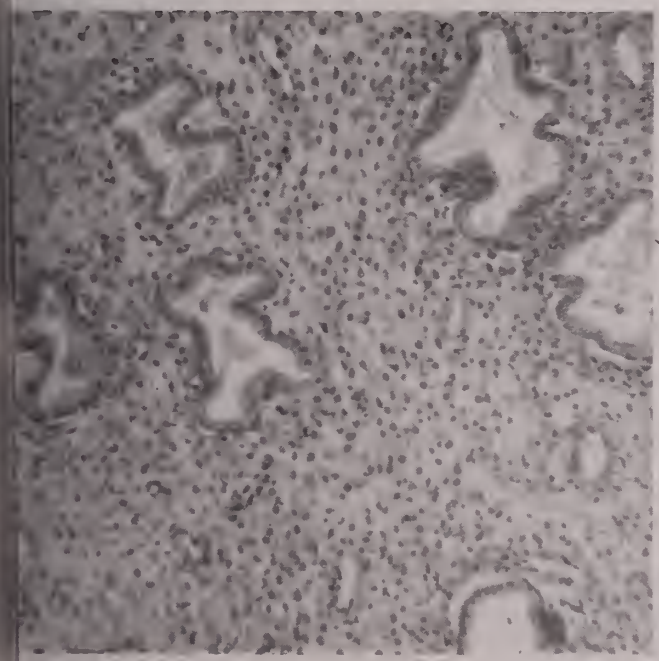
Immobile spermatozoa as they appear in cervical mucus taken from a patient treated with Norinyl-1.

How Norinyl-1 alters normal endometrial responses— another possible protective mechanism

et us suppose that an ovum is released—as occurs in an ccasional, rare case—and somehow a sperm succeeds in enetrating the cervical mucus barrier. Should this come about, ne additional action of Norinyl-1 may protect the patient om unwanted pregnancy. The theory is that progestogen intake akes endometrial tissue unreceptive to implantation.

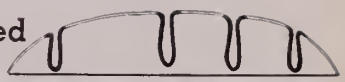
ndometrium of ntreated patient

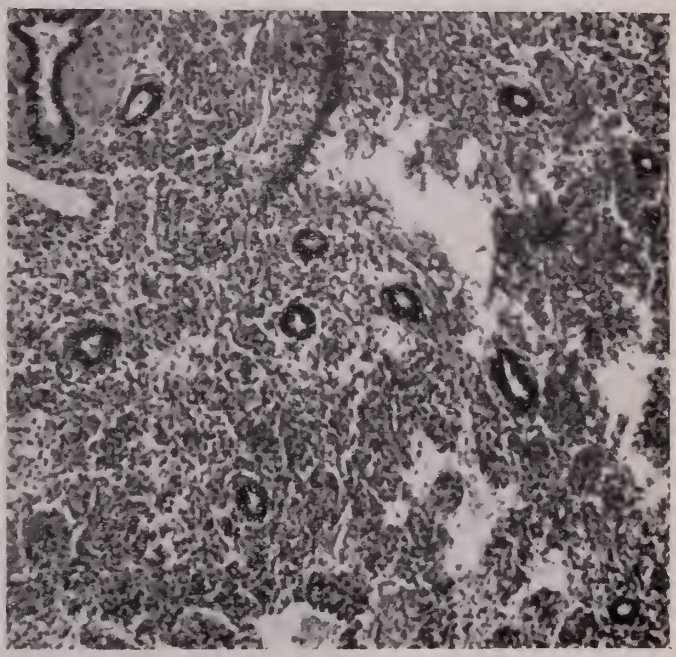




rmally, the endometrium progresses through proliferative phase stimulated by estrogen and a cretory phase stimulated by progesterone. ring the secretory phase the endometrium is ceptive to the fertilized ovum.

Endometrium produced by Norinyl-1





When Norinyl-1 is administered its progestogen component—norethindrone—accelerates the secretory phase and suppresses glandular and vascular development.

e last page for contraindications, precautions, side effects and dosage.

new Norinyl-1® tablets

(norethindrone 1mg. & mestranol 0.05mg.)

effective fertility control
on half the previous dosage

maintains ratio
of the established
norethindrone/mestranol
combination

lower cost

new Norinyl-1®

(norethindrone 1mg. c̄ mestranol 0.05mg.) tablets

Reduction of oral contraceptive dosage to lowest effective levels become a well-accepted principle of conservative medical prac In keeping with this view, Norinyl is now available in a new stren in which *both* norethindrone and mestranol are reduced 50 perc Studies show that Norinyl-1 achieves fertility control with only mg. of combined progestogen and estrogen per tablet.

Norethindrone was first reported for use as a progestational agen human beings in 1955. Norethindrone 2 mg. with mestranol 0.1 mg. an oral contraceptive, is currently in use by over 2,000,000 wor Clinical experience now establishes that Norinyl-1 also amply me the criteria of reliability and safety.*

*Symposium on Low-Dosage Oral Contraception, Palo Alto, Calif., July 15, 1965.

PRESCRIBING INFORMATION

Contraindications: 1. Patients with thrombophlebitis or with a history of thrombophlebitis or pulmonary embolism. 2. Liver dysfunction or disease. 3. Patients with known or suspected carcinoma of the breast or genital organs. 4. Undiagnosed vaginal bleeding.

Warnings: 1. Discontinue medication pending examination if there is sudden partial or complete loss of vision or if there is a sudden onset of proptosis, diplopia, or migraine. If examination reveals papilledema or retinal vascular lesions, medication should be withdrawn. 2. Since the safety of Norinyl-1 in pregnancy has not been demonstrated, it is recommended that for any patient who has missed two consecutive periods, pregnancy should be ruled out before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule, the possibility of pregnancy should be considered at the time of the first missed period. 3. Detectable amounts of the active ingredients in oral contraceptives have been identified in the milk of mothers receiving these drugs. The significance of this dose to the infant has not been determined.

Precautions: 1. The pretreatment physical examination should include special reference to breast and pelvic organs, as well as a Papanicolaou smear. 2. Endocrine and possibly liver function tests may be affected by treatment with Norinyl-1. Therefore, if such tests are abnormal in a patient taking Norinyl-1, it is recommended that they be repeated after the drug has been withdrawn for 2 months. 3. Under the influence of estrogen-progestogen preparations, preexisting uterine fibroids may increase in size. 4. Because these agents may cause some degree of fluid retention, conditions that may be influenced by this factor, such as epilepsy, migraine, asthma, cardiac, or renal dysfunction, require careful observation. 5. Although a cause and effect relationship has not been established, Norinyl-1 should be used with caution in patients with a history of cerebrovascular accident. 6. In relation to breakthrough bleeding, as in all cases of irregular bleeding per vaginam, nonfunctional causes should be borne in mind. In cases of undiagnosed vaginal bleeding, adequate diagnostic measures are indicated. 7. Patients with a history of psychic depression should be carefully observed and the drug discontinued if the depression recurs to a serious degree. 8. Any possible influence of prolonged Norinyl-1 therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study. 9. A decrease in glucose tolerance has been observed in a small percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be carefully observed while receiving Norinyl-1 therapy. 10. Because of the occasional occurrence of thrombophlebitis and pulmonary embolism in patients taking oral contraceptives, the physician should be alert to the earliest manifestations of the disease. A cause and effect relationship has not been demonstrated. 11. Because of the effects of estrogens on epiphyseal closure, Norinyl-1 should be used judiciously in young patients in whom bone growth is not complete. 12. The age of the patient constitutes no absolute limiting factor, although treatment with Norinyl-1 may mask the onset of the climacteric. 13. The pathologist should be advised of Norinyl-1 therapy when relevant specimens are submitted.

Side Effects: The following adverse reactions have been observed with varying incidence in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms, breakthrough bleeding, spotting, change in menstrual flow, amenorrhea, edema, chloasma, breast changes (tenderness, enlargement and secretion), loss of scalp hair, change in weight (increase or decrease), changes in cervical erosion and cervical secretions, suppression of lactation when given immediately postpartum, cholestatic jaundice, erythema multiforme, erythema nodosum, hemorrhagic eruption, migraine, rash (allergic), itching, rise in blood pressure in susceptible individuals, mental depression.

The following occurrences have been observed in users of oral contraceptives. A cause and effect relationship has not been established: thrombophlebitis, pulmonary embolism, neurooocular lesions.

The following laboratory results may be altered by the use of oral contraceptive creased bromsulphalein retention and hepatic function tests, coagulation test crease in prothrombin, factors VII, VIII, IX X), thyroid function (increase in PBI and nol extractable protein-bound iodine an crease in T^3 values), metapyrone test, preg diol determination.

Other side effects reported to have occ in association with use of this drug are ness, hirsutism, pains in legs, back, chest abdomen, dysuria, drowsiness, vaginal charge, libido increased and decreased, tions, hypermenorrhea, hypomenor increased appetite, G.U. infections, var veins, abdominal fullness, acne, head nervousness, allergies, blurred vision, pa eyes, and itching in eyes. *For complete cli data, see package insert.*

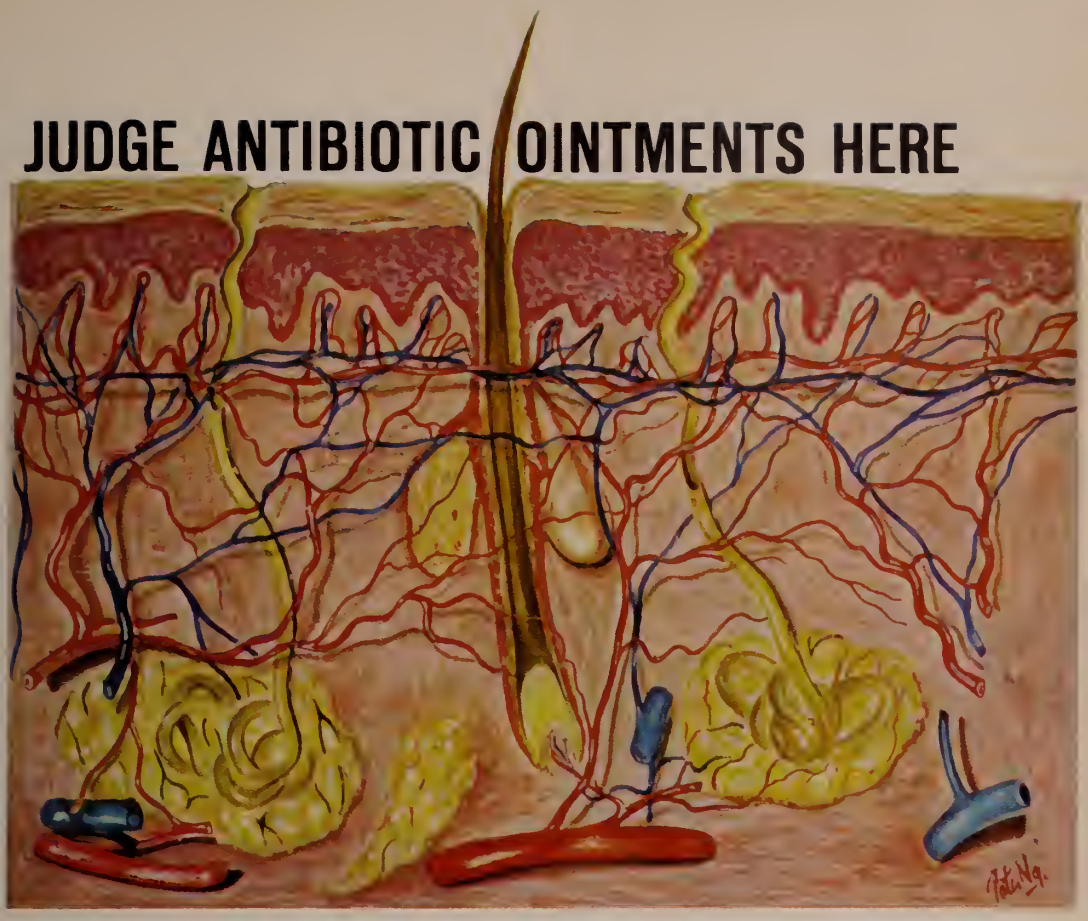
Dosage and Administration: 1. One tabl Norinyl-1 is administered orally for 20 beginning on day 5 of the menstrual (Count day 1 of the cycle as the first d menstrual bleeding.) Repeat this dosage s ule for each cycle. 2. If no menstrual p occurs after a cycle of treatment (20 table which patient adhered to the schedule, th tient must be instructed to resume takin Norinyl-1 tablets 7 days after the previo day course was completed. For example, last pill of a previous cycle had been tak a Sunday, then a new cycle of treatment s begin on the following Sunday. 3. In the partum woman, it is recommended tho first cycle of treatment should begin on of the first menstrual cycle. However, Not should not be administered during lactatic

Availability: Norinyl-1 (norethindrone with mestranol 0.05 mg.)—Dispensers of 2 60 and bottles of 250 tablets.

norethindrone — an original steroid from

SYNTEX LABORATORIES INC., PALO ALTO, CALIF

JUDGE ANTIBIOTIC OINTMENTS HERE



Results on skin are final proof of any topical antibiotic's effectiveness

No in vitro test can duplicate a clinical situation on living skin. 'Neosporin' (polymyxin B—bacitracin—neomycin) Ointment has consistently proven its effectiveness in thousands of cases of bacterial skin infection. The spectra of the three antibiotics overlap in such a way as to provide bactericidal action against most pathogenic bacteria likely to be found topically. Diffusion of the antibiotics from the special petrolatum base is rapid since they are insoluble in the petrolatum, but readily soluble in tissue fluids. The Ointment is bland and nonirritating.

Caution: As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs. Articles in the current medical literature indicate an increase in the prevalence of persons allergic to neomycin. The possibility of such a reaction should be borne in mind.

Contraindications: This product is contraindicated in those individuals who have shown hypersensitivity to any of its components.

Supplied: Tubes of 1 oz., ½ oz. with applicator tip, and ⅛ oz. with ophthalmic tip.

Complete literature available on request from Professional Services Dept. PML.

'NEOSPORIN'®

brand

POLYMYXIN B-BACITRACIN-NEOMYCIN OINTMENT

BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N.Y.



Phenaphen® with Codeine

the only leading compound analgesic that calms instead of caffeinates

Each capsule contains:

Phenobarbital (¼ gr.)	16.2 mg.
(Warning: may be habit forming)	
Aspirin (2½ gr.)	162.0 mg.
Phenacetin (3 gr.)	194.0 mg.
Hyoscyamine sulfate	0.031 mg.
Codeine phosphate	¼ gr. (No. 2), ½ gr. (No. 3), 1 gr. (No. 4)
(Warning: may be habit forming)	

Contraindications: Hypersensitivity to any ingredient.

Precautions: As with all phenacetin-containing products, avoid excessive or prolonged use.

Side Effects: Side effects are uncommon—nausea, constipation, and drowsiness have been reported.

A-H-ROBINS

A. H. ROBINS CO., INC., Richmond, Va. 23220



Government News

HEW Secretary Urges Expanded Medicare

The Administration urged the Senate to restore provisions chopped by the House in the $3 billion bill expanding social security health, welfare and retirement benefits.

Health, Education and Welfare Secretary John Gardner, first witness as the Senate Finance Committee opened hearings on the House-passed bill, asked the Senate to place the nation's 1.5 million under-65 disabled social security beneficiaries under Medicare, and to modify restrictions placed by the House on the Title 19 (Medicaid) plan for the medically indigent.

The Cabinet officer did not immediately comment on other Medicare changes in the House bill, such as permitting medicare patients to be reimbursed on the basis of an itemized statement of charges.

Discussing the disabled, Gardner said, "Because of their impairments, they have relatively high medical expenses and they have poor insurance protection against such expenses. We urge that the House bill be modified to extend the protection of hospital insurance to these beneficiaries."

He said the vote by the House to restrict federal Medicaid payments to those earning no more than 133% of the welfare eligibility income is "too constrictive a definition of medical indigency." Gardner said the limit should be 150%.

The lawmakers also were asked to adopt the higher cash retirement tax and benefit proposals of the Administration, and to reject the House provision cracking down on welfare payments to mothers with illegitimate children.

The American Medical Association presented its views on the legislation Aug. 28. AMA president Milford O. Rouse, M.D., gave the AMA testimony before the Senate Finance Committee.

The House approved the bill by a 415 to 3 vote under a procedure barring any changes in the measure as it was passed by the House Ways and Means Committee.

Three major revisions may be attempted on the Senate side. A group of senators have backed legislation to make outpatient drugs a benefit under Medicare's Part B program for medical fees. There is also some support among senators to reinstate the Administration's original proposal to make the 1.5 million disabled under age 65 who are receiving disability payments eligible for Medicare.

Important Medicare changes in the House bill which also raises social security cash benefits and the taxable wage base include tight limitations on those eligible for state Medicaid programs; Medicare reimbursement on the basis of an itemized statement of charges rather than a receipted bill; removal of initial certification for hospitalization; direct billing of Medicaid patients if the states permit; and inclusion of "non-routine" podiatrists' services as benefits.

Despite the many changes in Medicare, the House debate centered largely on the welfare provisions involving payments to mothers with illegitimate children. The bill freezes the number of illegitimate children to be allowed on the welfare rolls and orders state training programs for mothers.



He leaves to make an urgent call But doesn't use the phone at all

Parepectolin for quick relief of acute diarrhea
...soothes colicky pain with paregoric
...consolidates fluid stools with pectin
...adsorbs irritants with kaolin, and protects intestinal mucosa

Whether it's a 24-hour "bug", a food problem, or simply nervousness and anxiety, Parepectolin will bring the diarrhea under control until etiology can be determined. In some cases, Parepectolin may be all the therapy necessary.

Parepectolin®

Each fluid ounce of creamy white suspension contains:
Paregoric (equivalent)..... (1.0 dram) 3.7 ml.
Contains opium (¼ grain) 15 mg. per fluid ounce.
warning: may be habit forming
Pectin (2½ grains) 162 mg.
Kaolin (specially purified).... (85 grains) 5.5 Gm.
(alcohol 0.69%)
Usual Adult Dose: One or two tablespoonfuls three times daily.

RORER

WILLIAM H. RORER, INC.
Fort Washington, Pa.

Anesthesiology Grant Program

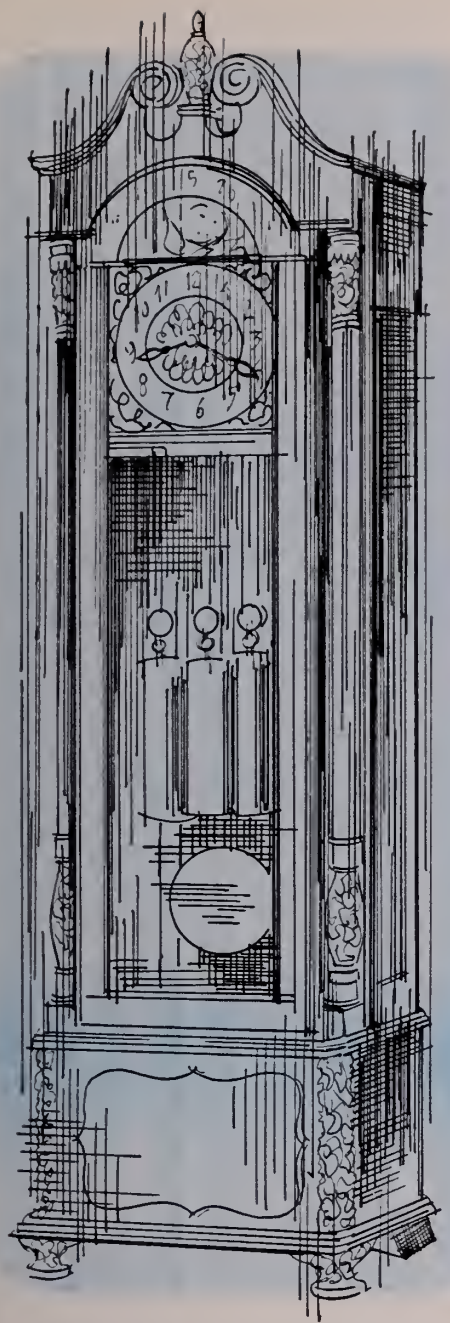
The Public Health Service recently launched a new grant program to upgrade the quality of training in anesthesiology and to attract more physicians to that speciality. Grants totaling $1 million are being awarded to 30 teaching hospitals in 21 states and in Puerto Rico for anesthesiology training programs.

Florida recipient institutions, amount of grants and training program directors are the University of Florida College of Medicine, $45,796, Joachim S. Gravenstein, M.D., and the University of Miami School of Medicine, $71,135, Frank Moya, M.D.

The new anesthesiology clinical training grants provide support for up to three years of full-time training leading to qualification for examination by the American Board of Anesthesiology. The grant funds pay stipends, allowances for dependents, partial salary support of instructors, costs of special courses, permanent equipment and supplies.

Under the training grant program, physicians who go directly from internship into an anesthesiology residency will receive stipends of $6,500 the first year and annual $500 increases each of the following two years, plus allowances for dependents.

Physicians who have been in practice for at least four years and who decide to specialize in anesthesiology will receive higher stipends and the length of their training will depend on their experience, professional background and other factors.



IN UROLOGY, TOO,

YOU CAN'T TURN BACK THE CLOCK

Many urologic problems in older patients are as much the result of the aging process as the consequence of any specific disease process. The aging bladder may lose its resistance to infection. The prostate gland may not be sufficiently enlarged to require surgery, but can cause intermittent difficulties in micturition. Post-menopausal atrophy of the genital organs may also involve the lower part of the urinary tract.

URISED®

Each blue-coated tablet contains active:

Atropine Sulfate	0.03 mg.	Methylene Blue	5.4 mg.
Hyoscyamine	0.03 mg.	Phenyl Salicylate	18.1 mg.
Methenamine	40.8 mg.	Benzoic Acid	4.5 mg.

Even though they cannot be permanently cured, these patients demand and deserve relief. URISED is an agent which you can prescribe with confidence. It has a mild antibacterial action, a mild antispasmodic action and helps to soothe the irritated bladder and urethral mucosa. For over 50 years URISED has exhibited no toxic effects — even on prolonged use. And the presence of methylene blue in the urine is indicative that the medication has been taken by your patient.

INDICATIONS: URISED is safe... especially useful in long-term management of chronic cases; as a prophylactic measure with catheterization or after instrumentation. No systemic reactions or bacterial resistance have been reported.

URISED rapidly exerts spasmolytic action, relieving pain and discomfort of urgency, frequency, and burning on urination.

Rapid acting URISED exerts antibacterial action against uropathogens susceptible to methenamine and methylene blue, in an acid medium.

PRECAUTIONS: Administer with caution to persons with atropine idiosyncrasy or cardiac disease. While under this therapy the urine is blue; patients should be so advised to allay apprehension.

SIDE EFFECTS: If pronounced dryness of the mouth, flushing, or difficulty in initiating micturition occur, decrease dosage. If rapid pulse, dizziness, or blurring of vision occur, discontinue use immediately. Acute urinary retention may be precipitated in prostatic hypertrophy.

CONTRAINDICATIONS: Glaucoma, urinary bladder neck or pyloric obstruction, duodenal obstruction and cardiospasm. Hypersensitivity to any of the ingredients.

DOSAGE: Adults—Two tablets, orally, four times per day, followed by liberal fluid intake.

Acute cases: Initially two tablets every hour for three doses, followed by the recommended daily administration.

Children: One-half the adult dose.

(Stocked nationally through all service wholesale druggists)

CONAL
PHARMACEUTICALS, INC.
CHICAGO, ILLINOIS 60640

MANUFACTURERS OF URICEUTICAL® SPECIALTIES

• CYSTOSPAZ® • URISEDAMINE® • ŪTRASUL® Tablets and Suspension

easy does it!

tear, moisten, compare–that's all!





Scientific Section

Symposium on Back Problems

In the September 1964 issue of the Journal of the Florida Medical Association an important precedent was set. In that issue the Journal, for the first time, presented a symposium upon a specific disease—a Seminar on Myocardial Infarction. The issue contained an editorial hope that the articles comprising the symposium would sharpen the reader's acumen and stimulate him to more accurate diagnosis and more effective therapy.

Two more issues were to follow this noteworthy precedent. The January 1966 issue of the Journal presented a Symposium on Trauma. The next month, February 1966, saw the presentation of a Symposium on the Recurring Urinary Calculus. The latter symposium was so well received that it was reprinted in part, complete with the editorial that accompanied it, in the August 1967 issue of Current Medical Digest.

It is hoped that the Symposium on Back Problems to which this issue is devoted will prove a worthy successor to those that have gone before it in the effort to further enlighten the medical community.

We are especially grateful to Dr. Albert A. Wilson of Tampa, who coordinated the symposium for the Florida Orthopedic Society in a very thorough manner. The papers appearing in this issue, specially prepared by orthopedists throughout the state, present the broadest possible coverage of a complex subject that the available space would allow.

It is with pleasure, then, that the Journal presents this Symposium on Back Problems. We sincerely hope it will prove to be yet another rung in the Journal's ladder toward the finest possible scientific literature for the members of the Florida Medical Association.

T.M.

Adult Postural Back Pain

CHARLES A. MEAD JR., M.D.

The low back can become decompensated and cause pain and functional disability as does the heart. Its decompensation may be acute or chronic.

Acute decompensation may result from simple overloading, as in lifting strain, and cause acute lumbosacral sprain. It may also result from relatively light or normal activity done when the person is fatigued, chilled or ill with systemic disease. An acute back sprain probably results in stretching of the ligaments and joint capsule, perhaps with some pinching of soft tissue between the facets or other bony structures. The annulus fibrosis may be injured, but usually is not.

Chronic low back decompensation results from gradual weakening of the supporting musculature of the back. With loss of normal muscle support, the joints and interosseous ligaments are subjected to repeated small traumata in the course of daily activity causing local swelling, irritation and resultant pain or aching.

Chronic back decompensation will occur more quickly in the obese person for obvious reasons. It will also occur sooner in persons having an imbalance of postural forces in the low back, as in hyperlordosis. This causes compression strain on the facets and other posterior elements with resultant erosion of cartilage, sclerosis of bone and osteophyte formation typical of osteoarthritis. Impingement of spinous processes by the hyperlordosis is thought by some to be a cause of pain.

Imbalance of postural forces also occurs in persons with lateral pelvic tilt as in leg length inequality, unilateral hip disease with hip joint contracture or in congenital lumbosacral asymmetry.

Acute and chronic adult postural back difficulties occur in different age groups. Acute low back sprains occur most frequently in the third decade when athletic activities are usually less and before the stiffness from normal aging has occurred. This lack of good muscle strength and reflexes occurring at a time when joint mobility is still good permits the acute strains.

In the fourth and fifth decades we see more of the chronic decompensation because the low back joints are now sufficiently stiff to prevent abnormal motion. In this age group the obesity factor and the chronic postural defects are more common.

After the fifth decade fewer people complain of low back pain, perhaps because normal degenerative changes have stabilized the low back. Older people complain instead of their knees, hips and feet.

Treatment

Treatment of the acute low back sprain consists of rest (either bed rest, strapping or the use of a corset), pain-relieving medication and sedatives. Muscle relaxants are useful in the acute sprains and strains.

After the acute symptoms have subsided, a careful re-examination should be done, as many tests and measurements cannot be done during the acute stages of the injury. Any leg length inequality or other cause for pelvic tilt should be corrected at this time.

The problem of obesity can now be attacked with diet regulation, appetite suppressants and other related measures. This is one of the most difficult areas in which to get full patient cooperation but is one of the most important and most fruitful when accomplished.

Thirdly, muscle rehabilitation should be begun with gradually progressive active exercises to the muscles of the trunk, pelvis and lower extremities. Do not merely hand the patient a folder of exercises, but show enough interest in his case to demonstrate the exercises personally, check his performance of them and indicate the frequency and vigor with which he is to do them. We have found recumbent exercises to be fully capable of restoring muscle strength, tone and coordination without as much risk of reinjury to the joints as with exercises done standing. We have no rigid routine and vary the exercises for each patient, but, in general, we use the following:

(1) Lying supine, support lumbar spine with hands, set right quadriceps and gradually raise leg to maximum straight leg raised position and then lower slowly to floor, relax.

(2) Tighten left quadriceps, raise left leg straight, lower, relax.

(3) Tighten both, raise both, lower, relax, rest.

Turn to prone position and support low back with hands behind back.

(4) Tighten right quadriceps, raise right leg straight up behind, hold, lower, relax.

(5) Repeat with left.

(6) Tighten both, raise to maximum, keep elevated while scapulae are adducted and upper spine extended, raising chest and head from floor, lower, relax.

We stress the proper setting of the muscles being used ("ready position") and the smooth performance of the motion with no jerks, snaps, grunts or groans. No exercises are repeated until they can be repeated with no pain. Exercises are gradually increased in frequency and vigorousness as tolerated until all symptoms are gone for six weeks and then a maintenance program is suggested for continued fitness.

The fourth item in the treatment regimen is to correct postural faults in standing and sitting posture by showing the patient how to flatten a lumbar curve by pelvic flexion, raising the rib cage, tightening the abdominal wall, squaring the shoulders and getting the head and neck correctly set. This is quite a chore for most patients with chronic postural faults to understand and accomplish. Much patience is needed. Lastly, a careful review with the patient of the fundamentals of proper body mechanics in the activities of daily living must be done. We call it "low back hygiene" and although this term suggests a Sitz bath to some, it means to us the detailed instruction to the patient in how to rise from recumbency and from the sitting position, how to pick up articles from the floor, how to dress and undress, how to get in and out of the car and even how to make love.

Because of their many similarities we have likened the orthopedist and his low back patient to the internist and his heart patient, whether his condition be acute, chronic, convalescent or "cured."

Dr. Mead, 1300 Gary Street, Jacksonville 32207.

Back Disorders in Children

ROBERT P. KEISER, M.D.

Disorders of the spine in children are many and varied and while they have not, in most instances, received the popularity or notoriety that have back problems in the adult, are potentially more serious and long-lasting in their effects.

In general, these abnormalities of the spine can be divided into those of a congenital origin and those of an acquired nature. Newborns with congenital anomalies of the spine often have associated anomalies of the trunk (ribs, scapula) as well as anomalies of the nervous system (meningomyelocele), which lead to functional abnormalities of the extremities, bladder and bowel. Table 1 will serve as a guide in categorizing these problems.

Congenital anomalies without involvement of the nervous system usually present no great problems or urgency of management in infancy. Later, as growth progresses, these may cause alterations in vertebral alignment with the development of a scoliosis, kyphosis or a combination of both, and should be recognized and dealt with in a proper manner as early as possible.

Anomalous conditions associated with nervous system abnormalities such as myelomeningocele should be surgically treated as early as possible. These are usually associated with orthopedic problems of the extremities due to muscle paralysis or paresis, trophic changes in the skin and bladder and bowel incontinence.

Of the infectious processes affecting the spine, tuberculosis, once the most common, is extremely rare, particularly in Florida.

More common, although still somewhat rare, is the intervertebral disc space infection probably due, in most cases, to the Staphylococcus aureus. We have recognized and treated 16 disc space infections at Variety Children's Hospital in the past 15 years. Disc space infections are more commonly seen in the younger age group of three to eight and are manifested by the febrile or irritable child who resents movement of the back and generally refuses to walk, or, at best, walks with a limp. The child is usually not acutely ill and may have a slightly elevated temperature and the usual laboratory findings of a low grade infectious process. Roentgenographic evidence of changes is usually not seen for about two weeks following the onset of symptoms and is manifested by an early, subtle narrowing of the disc space later progressing to complete obliteration.

Vertebral epiphysitis, also known as Scheuermann's disease, juvenile kyphosis or adolescent round back, is one of the most common conditions affecting the growing spine and manifests itself by an increased, or round, back which may be passed off as a "teenage postural slump." It is more common in boys and usually seen in the mid teens in boys and the early teens in girls, at the time of a relatively rapid growth spurt. It is due to structural wedging of the anterior portions of the vertebral bodies, some narrowing of the intervertebral disc and irregularity of the vertebral growth plate. Pain may be associated with activity, usually relieved with rest, in addition to the deformity. These are best treated by a simple back brace if the deformity is minimal, or a Milwaukee brace if the deformity is sufficiently marked to justify correction for postural reasons.

Lateral curvature of the spine, or scoliosis, is probably more common in growing children than most physicians realize. At least 85% of children fall in the idiopathic classification. The term correctly expresses our knowledge as to its etiology. It is most commonly seen in girls and manifests itself subtly in the beginning and generally is not

Table 1. — Disorders of the Spine in Children

Congenital Anomalies

1. Hemivertebra, block or unsegmented vertebra
2. Vertebral agenesis most common in the lower spine, such as the sacrum
3. Vertebral arch defect, such as spina bifida with involvement of the spinal cord and meninges as in meningomyelocele
4. Inadequacy of the pars interarticularis—spondylolysis and spondylolisthesis

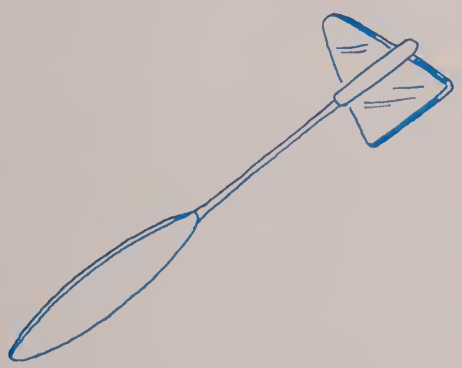
Acquired Disorders

1. Infections
 a. Vertebral body and its appendages
 b. Intervertebral disc space infections
2. Primary abnormalities of growth and development
 a. Epiphysitis — Scheuermann's disease (round back)
 b. Heritable disorders (Morquio's disease, Hurler's syndrome, Marfan's disease)
3. Secondary abnormalities affecting growth and development
 a. Metabolic disorders
 (1) Rickets
 (2) Osteogenesis imperfecta
 (3) Osteoporosis (cortisone effect)
 b. Scoliosis—idiopathic
 c. Scoliosis—paralytic (polio, muscular dystrophy)
4. Disorders of the hemopoietic system
 a. Leukemia, Hodgkin's disease
 b. Sickle cell anemia
5. Tumors
 a. Benign (hemangioma, osteoid-osteoma, aneurysmal bone cyst
 b. Malignant (Ewing's tumor, primary expansile tumors of the spinal cord or meninges)
6. Trauma
 a. Fractures of the vertebral body or its processes
 b. Dislocations
7. Juvenile rheumatoid arthritis

recognized by the parents, or physicians, until it progresses rather rapidly at the time of a growth spurt (girls—9 to 12 and boys—12 to 14). It is extremely important that scoliosis be recognized as early as possible. It can be recognized simply by having the patient bend forward during a routine examination. The associated rotation will cause a rib prominence on one side and one iliac crest is usually higher than the other, as is one shoulder. A high percentage of these will progress during growth. If seen in an early stage, many can be controlled, or even reversed, by special bracing. If seen after they have reached considerable magnitude, surgical correction is the only available method of treatment, and this entails a long tedious convalescence. If left untreated and allowed to reach a magnitude of 60 to 70 degrees or above, they will most certainly be the source of pain as the child grows older, and will seriously compromise pulmonary or cardiopulmonary function or both, thus decreasing the ordinary life expectancy of the child. There is no place in the therapeutic regimen of a growing child, once this condition is recognized, for "watchful waiting" or other less aggressive measures.

Most of the other back disorders in children manifest themselves primarily by pain or evidence of other associated, or causative, systemic disease and can be recognized by adequate clinical evaluation and roentgenographic studies.

Dr. Keiser, 263 Aragon Avenue, Coral Gables 33134.



Spine Fractures Involving the Trunk

DAVIS S. BOLING, M.D.

Fractures of the lumbar and dorsal spine are commonly seen, and in this paper I will discuss recognition and treatment of these fractures together with the involved mechanism of injury and management of certain complications as a result of these fractures. This presentation is not intended as a discussion of fractures which are extensive enough to produce direct neurologic damage to the spinal cord or nerve roots.

Etiology

Trauma is the precipitating factor in an otherwise healthy spine. No figures were available regarding the force necessary to compress a healthy vertebra. The usual mechanism of injury is one of compression leading to a relative decrease in the vertical height of the anterior portion of the body of the vertebra. In addition to direct compression, an element of flexion usually is associated, and this results in the classic wedging of the anterosuperior portion of the vertebral cortex. In most instances there is some buckling of the anterior cortex with moderate compression of the cancellus and cortical bone into a more dense, compact mass. In the usual case there is no surrounding damage to the disc or neurologic structures, either intraspinal or where they traverse the foramina. In cases of extreme trauma, of course, exceptions do occur and require much more vigorous and aggressive management.

Physical Findings

The adult patient usually presents with local pain at some location of the trunk resulting from a fall from a height or, occasionally, a direct blow to the posterior shoulder area. The patient also may complain, however, of deep abdominal pain with girdle-type pains radiating about the abdomen or groin. Usually local tenderness is noted over the fractured vertebra and occasionally there is sufficient deformity to produce a visible and palpable gibbus. In cases seen a few hours after injury, there usually appears an accompanying ileus in various degrees of severity. The abdominal ileus may be so mild as to pass unnoticed, or may be severe enough to cause complete temporary arrest of peristalsis with resulting nausea, bloating, vomiting and eventual electrolyte imbalance. Bladder symptoms also occur and usually present as an inability to void, necessitating catheter drainage. True incontinence is rare and should lead one to suspect associated neurologic damage. One should suspect associated injuries of the spine with fractures of the os calcis, as the os calcis injury frequently is the more painful and associated fractures of the trunk could be overlooked.

Principles of Treatment

(1) Recumbency on a firm bed supported by boards. No early attempt at reduction.

(2) Adequate narcotics or analgesics for the relief of pain.

(3) Oral intake restricted to liquids in anticipation of ileus.

(4) Aggressive treatment for adynamic ileus occasionally is necessary.

(5) Careful x-ray evaluation to rule out damage to the posterior elements of the spine.

Details of Treatment

Pain resulting from a spinal fracture is not always severe and often can be detected only on examination by forceful percussion of the spine. A noticeable gibbus is present in severe degrees of flexion only. Motion generally aggravates the pain; recumbency relieves it.

The ileus responds well if oral intake is restricted to cracked ice or clear liquids until the peristalsis is established; a regular diet may be instituted, in average cases, from three to four days later. Rarely is there reason to insert a gastric tube. Supplemental fluids intravenously administered for one to two days when vomiting is present often will result in better general condition than if the patient is allowed to become dehydrated.

In youngsters and adults to 35 years of age the spinal fracture is not common, but when

present, the method of support is usually a plaster jacket. I prefer an extension jacket from the symphysis to the sternum placed while the patient is lying in a hyperextended position on a special fracture table or between two stretchers. Some effort is made to correct the deformity in a severely compressed vertebra in the young age group by forceful extension of the spine under anesthesia before applying the cast. Judicious use of the procedure is advised, however, to prevent the error of manipulating an unstable vertebra, such as a posterior element fracture, thus causing neurological damage where none previously existed or worsening pre-existing neurological loss. This is less likely to occur in the lower part of the spine where the cauda equina has already formed.

No complicated orthopedic table or frame is needed to accomplish the application of this cast. Two stretchers or tables will do nicely. The patient is placed between them on his abdomen with the edge of one table across the upper part of the sternum and the edge of the other across the pubic symphysis. It is advised, however, to await passage of acute pain and ileus before applying the plaster cast as this can be a painful procedure.

Having accomplished application of the cast in a form tolerable for the patient, ambulation can commence immediately and the patient can resume normal activities with instructions to avoid lifting or heavy use of the body.

For the older person, a brace is preferable to a cast because it is cooler, equally effective and removable for sleep and for showering. In my experience, old people generally tolerate braces better than they do casts.

Knight and Taylor spinal braces and the Jewett hyperextension brace are effective for mid and high lumbar fractures, while a single chair-type brace does nicely for L4-L5 lesions. None of these prevent further compression with healing.

My results with the hyperextension brace are directly related to the selection of patients. Older persons do not tolerate the extended position well and occasionally will reject the brace. For those who will tolerate it, the brace is light and effective. Most important with any brace is the use of an underlying tee shirt to prevent chafing. The brace is not needed for sleep.

Three months of support is adequate for the fracture of a stable vertebra and, as a rule, the brace or cast can be discarded at that time. I believe extension exercises of the lumbar spine are of some help after removing the brace from a younger person.

Some consideration must be given to transverse process fractures. The mechanism here appears to be a traction fracture by supporting muscles of the spine. The processes are pulled off on the convex side of the laterally flexed spine and, of course, are associated with hemorrhage into the muscles. No effort is needed to replace them, as they usually resume a basically normal relationship. For multiple transverse process fractures, hemorrhage may be moderate and a check should be made of the patient's blood pressure and pulse in the early hours after injury. Treatment here is again analgesics, rest and early ambulatory treatment, utilizing a lumbosacral corset for three to six weeks.

Unstable fractures are those in which there is damage of the bone fragments traumatizing the neural structures. Vertical fractures with the fracture line in the sagittal or coronal plane are sometimes associated with the posterior protrusion of bone fragments or disc material into the neural canal. Laminal arch or pedicle fractures fall into this category as well and must be recognized when there is an unstable posterior element fracture, such as a fracture in which motion of the spine is likely to dislodge the pedicle or posterior arch. Forced bed rest in a hard bed or a turnable frame is indicated until enough callus forms to make casting safe. A minimum of three weeks and as long as eight weeks may be required, with casting or bracing to follow. Extended immobilization is longer in these cases partly due to the associated concern for neurological damage and because there is more cortical than cancellus bone involved in the posterior arch.

Special consideration of fractures in the patients with senile osteoporosis will be mentioned elsewhere in this special issue of the Journal. Mechanical management is similar to that for traumatic fractures.

Summary

This paper presents a brief discussion of lumbar spine fractures without associated paraplegia or root symptoms and methods of general management are suggested.

▶ Dr. Boling, 603 South Boulevard, Tampa 33606.

Disability Evaluation of the Back

WENDELL J. NEWCOMB, M.D.

Disability evaluation of the back is a complex problem. It might be evaluated by several doctors and the average percentage taken. Some believe that the doctor who has seen the patient and cared for him gives a more accurate disability evaluation. On the other hand, I have on many occasions thought that the examiner who sees him once can summarize the major points and give an accurate evaluation. The doctor who sees the patient frequently does not see the forest for the trees. He is more apt to think more highly of his work than the other examiner and give a lower permanent partial disability.

I will not attempt to state the percentage of disability that should be given for certain injuries or certain degrees of motion. I believe that if one has studied the following references he will render a more satisfactory percentage of disability evaluation.

1. Disability Evaluation by Earl D. McBride, published by Lippincott.

2. Evaluating Permanent Physical Impairment: The Manual for Orthopedic Surgeons, published by the American Academy of Orthopedic Surgery, 29 E. Main Street, Chicago.

3. Guide to Evaluate Permanent Impairment of Extremities and the Back: The Journal of the American Medical Association, published by the Committee on Medical Rating of Physical Impairment, Feb. 15, 1958.

4. The Florida Workmen's Compensation Laws, as amended in 1959.

One should not evaluate a permanent partial disability of the back by examining the back alone. The findings upon examination of a back are not only related to the back, but the entire anatomy, and one should therefore acquaint himself with the entire patient. The medical, neuromusculoskeletal, special senses, genitourinary, psychiatric and environmental factors will interact to affect the patient's functional ability.

The actual function of a back is difficult to evaluate in an office examination. Examiners seldom have methods of evaluating the actual lifting strength. Frequently the range of motion and other findings that should be objective and concrete are altered by the patient's functional reaction or behavior.

I believe that anyone evaluating a permanent partial disability should be of a positive opinion. He should study the previously mentioned references and the subject of his examination sufficiently to be positive in his statement. Those who have the responsibility of making the final decision for the patient are at a total loss if the evaluating physician is not positive in his answers so that they can arrive at a concrete conclusion. The rating given should be the doctor's opinion rather than the opinion of a rating book. The rating books, and the short bibliography mentioned earlier are for reference only. Anatomical damage is a good basis on which to make a concrete opinion, but even this is sometimes misleading. We have all seen patients with a nonunion of a lumbar fusion who have a very good functional result. In other words, we cannot establish a permanent partial disability by one facet of the examination, such as an x-ray. The evaluation must be the doctor's opinion and he must have a concrete summation of the functional ability of the examinee. If this cannot be done in one examination, reevaluate.

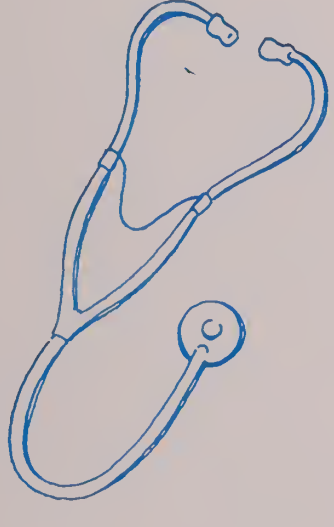
Disability evaluation is a thankless task. If you have cared for a Florida Workmen's Com-

pensation case, it is your duty to perform this service without additional charge. Many a doctor has lost his patient as an appreciative person when he sets about to evaluate his permanent disability. Regardless of the fact that the physician may have done him a great medical service, his friend and patient becomes antagonistic if rated 5% or 10% less disabled than he expected. Many patients would not be happy unless rated 105% disabled. If the examiner detects this type of patient before he undertakes to establish the permanent partial disability, I believe he should request a disability evaluation from another examiner.

I think that we frequently try to establish a permanent partial disability too soon. When we say permanent we mean that the patient will have it for many years to come and it is frequently impossible to determine how a back will function until considerable time after a severe injury. The benefit of an early disability evaluation is usually to conclude the case so that the patient can get the process behind him and the insuring company can complete its papers. The contraindication in delaying the permanent partial disability estimation is that the patient sometimes thinks he should stay in an exaggerated disabled state to insure that he gets more than he should. This attitude and mental fixation of the patient are contrary to a good recovery; so frequently we produce early estimation of the permanent partial disability to enable the patient to assume his future attitude.

We should be diligent in evaluating disabilities and we should make as positive a statement as possible. We should have a thorough knowledge of the previously mentioned references, and when possible we should discuss our findings with the patient. If the patient and/or the examiner is dissatisfied, we should then feel perfectly free to request another evaluation by an independent examiner who does not know what percentage of disability you have rendered the patient.

▶ Dr. Newcomb, 14 West Jordan Street, Pensacola 32501.



Decisions of Care in Back Operations

WALLACE E. MILLER, M.D.

It is difficult to arrive at a decision regarding the need for surgery in a back problem because the evaluation and diagnosis must be made over successive visits rather than at any one particular time on one patient visit. Even if one can determine the cause of back pain or complaints, there are no rigid criteria indicating surgery. For this reason the comments need to be generalized, with an application of certain points that have to do with individual problems.

There are mechanical causes for back pain which eventually lead to surgery. It is seldom that surgery will be necessary after moderate trauma that might result in severe lumbosacral strain or ligamentous tearing. A popular diagnosis in the past has been sacroiliac strain. This is seldom considered an entity nowadays. Some severe trauma may eventually lead to surgery, but even this is unlikely.

The mechanical cause that we think of in terms of a surgical entity is usually the disc syndrome; and even in this instance most of the patients with the so-called disc syndrome will need to have gone through a conservative observation period prior to the final decision for surgical intervention. The surgery that is being discussed in this paper seems particularly applicable to the complaints in the low back which are generally called lumbar or lumbosacral unstable back problems. They may be due to degenerative disc disease, congenital malformations, arthritis or residual post-traumatic degeneration. It is generally considered reasonable to have had the patient go through a diet for loss in weight, certain postural strengthening exercises for back and abdominal musculature, a change of certain aspects of daily living that may reduce the strain of a back and an observational period with some type of back support prior to the decision for surgery.

There is no need to delay with conservative treatment once one has decided about the aspect of care that needs to be instituted when it is obvious that operative treatment will become necessary. All of us are not masters of the art of the practice of orthopedic surgery, however, and it becomes difficult to decide when to abandon conservative treatment and which cases to select for early operative intervention. Certain problems lend themselves to easy decisions of care. For instance, in the acutely injured back in a young person, when the injury has been the result of heavy lifting and the physical findings as well as the positive myelogram all point to an acute protrusion or extrusion of an intervertebral disc, then there is no doubt that surgery is indicated. It becomes more a matter of trying to decide whether or not to incorporate a fusion procedure as part of the operation.

Similarly, laboratory findings are frequently indicative of proceeding, regardless of all other findings. For example, we pay a great deal of attention to a highly elevated total protein content in the cerebral spinal fluid, especially when this is associated with a protruded intervertebral disc or in any instance when a tumor may be involved. Another example of a decision of care

Professor and Chairman, Department of Orthopaedics, University of Miami School of Medicine, Miami.

that is easy to make is the case with x-ray findings of spondylolisthesis where there is a first degree or second degree slipping and symptoms that have begun to indicate extension of pain in the low back and into the back of the thighs. In a case such as this the decision of care is not whether or not to operate, but, perhaps, on the technique of the operation and what type of fusion procedure to utilize. In addition, there is the responsibility of the surgeon who is first to operate on a back to do all that is important to be done on that first operation, and to make it the last operation as well. The problem, however, seems to involve more in those cases that end on the borderline as to the decision to operate. Significant considerations for my final evaluation prior to a decision for operative intervention are:

Mechanism of Injury

Whether the patient is young or old, the important point is the manner in which the injury has been sustained. An injury sustained as a result of an automobile accident, particularly one that is involved with litigation or some aspect of "wrenching" of the back, would be a type to guard against. This type of back injury needs to have prolonged conservative treatment of a nature drastic enough for the patient to believe that the pursuit of care is adequate. On the other hand, the injury sustained when the patient feels a sharp "snapping" in the the back during a lifting process would be one that may involve an acutely protruded disc and will call for surgical intervention. One must keep in mind that even in a case such as this, nearly 85% of the original disc injuries will subside with conservative care, although they may not get entirely well. The patient who can remember the exact day and the exact cause of injury is the one to whom to pay particular attention regarding the history and exact mechanism of injury. In many instances patients would like to tie all of their complaints into one particular episode of injury even though they may have had difficulty with the back for months or years prior to that injury. One must guard against the patient who would "ring in" all aspects of his back complaints to one particular incident so that he will not have the cost of medical care to solve his problem. To be able to sift out the aspects of the history and incidents in his back history before coming to your decision of care may require a bit of medical detective work on your part.

Age of The Patient

The second point for attention on your part is the age of the patient. The young back is one that will heal well and do well on conservative treatment. In addition, the young back is one that lends itself well to operative work and faster healing. We are, therefore, apt to find a greater number of our patients who will be considered for surgery falling within this younger age group of those under 50. As one proceeds on into the elderly age group, however, there are still many heavy-lifting jobs and other reasons for acute injury that may require us to proceed with operative intervention, even though the patient seems to be approaching the elderly class. A fusion later in life can be less of a disabling approach to the patient's problem, however, than asking a person well along in years to live with a painful back which could be improved with a facetectomy and a laminectomy to decompress nerve root pressure. In other words, it may not always be necessary to remove discs or to do extensive work on a back. With the patient having a gradual loss of intervertebral height, there may be consideration for eliminating certain painful motions in the back by performing facetectomy from L3 through S1 and putting the patient in a rigid corset or back brace for six months to a year thereafter. Most of these patients are not as active as the young person and will be willing to accept the extra brace support as part of the operative procedure. I do not believe, therefore, that the age of the patient should limit one in the decision of care; rather, it is important to pay attention to the history, physical examination and mechanism of injury.

Type of Pain

The type of pain is extremely important in the decision of care. I would think that localized low back pain at the intervertebral space on either the left or right side, in relationship to the low back from L4 through S1, when it is persistent, even after conservative treatment or following brace application, would be reason enough to seriously consider operative intervention. I am more concerned with the localized back pain and, perhaps, the slight extension of pain into the

buttocks, than I am with the radiating type of pain that we so frequently look for in relationship to disc or nerve root problems. It seems to me that the radiating pain is more difficult to evaluate than the persistent low back pain. I find the textbooks do not stress enough the fact that radiation of pain can frequently come into the anterior aspect of the groin and thigh and frequently, in the male, extend into the testicles. Pains such as this will nearly always be relieved by a hemilaminectomy. Since one can easily be led astray by the "seeming amount" of pain, one should be extremely careful not to be trapped into operating on the patient who has an extremely low threshold of pain and will continue to have pain after an operation.

Previous Back Complaints

An additional significant aspect is the presence in the patient's history of previous episodes of back complaints. Although patients many times will try to hide some aspects of their previous complaints, wanting to impress us with their present problem, it is important to elicit any hidden history, since the patient who has experienced several previous episodes of back trouble is more a candidate for operative intervention than one who has not. Conversely, the patient who is experiencing his first episode of acute pain in the back should be more a candidate for the conservative plan of treatment than one who has had many previous episodes. Residual damage in each instance, especially if it occurred more than five to seven years ago, will frequently result in narrowing of disc space or changes in the bone edges, revealing a certain amount of whitening or sclerosis of joint margins. This type of history should also alert you to consider other possibilities such as gout, multiple myeloma, myasthenia gravis or that insidious disease in the young male, Marie-Strumpell disease, before deciding upon operative intervention.

Patient Type

The type of patient must also be considered in your decision. Mental attitude and body build are two of the more important factors. For instance, I do not believe the operative approach is necessarily the best one when dealing with a patient who has a mild degree of hysteria. There is a large group of psychophysiologic patients, including malingerers, conversion reactors and those with mild depression syndromes, who will persist with complaints after an operation. In addition, the patient's body build should play an extremely important part in your decision. The obese patient will put a great deal of strain on the back following operative intervention and one must face the fact that an operation will temporarily, at least, weaken the back. If one cannot fit a brace well on a patient because of obesity, the same problem will still exist after an operation when a cast or back support may be needed. It is extremely important, therefore, to prescribe a diet for the obese patient prior to the time of the operation. In addition to the obesity factor, one must take into consideration postural factors which may be putting a great deal of strain and stress at the site of a fusion. If there is some aspect of stress that needs correcting, either by technique and/or type of operative procedure or with a holding brace to be used after the operation, one must consider this prior to the operation rather than afterward.

Roentgenographic Findings

I have purposely avoided discussing the exact relationships of the roentgenographic findings to a decision of care in back operations. Much has been written about this subject, particularly in relationship to congenital anomalies such as the transitional lumbosacral vertebra. One also could get into discussion of the narrowing of the intervertebral joint, subluxation and sclerotic changes of articular facets, the lumbosacral angle and, of course, spondylolisthesis, with or without spondylolysis. Roentgenographic findings in themselves are, as I mentioned previously, merely one aspect of the findings which may be collated with the patient's history and physical examination, but must not be considered independently as sufficient reason for operative intervention. The majority of these patients could just as well be treated with a brace or some type of back support, rather than an operative procedure. A period of external immobilization of the low back may indicate whether or not internal immobilization in the form of a back fusion will similarly offer the patient relief.

Special Consideration for Multiple Operative Procedures

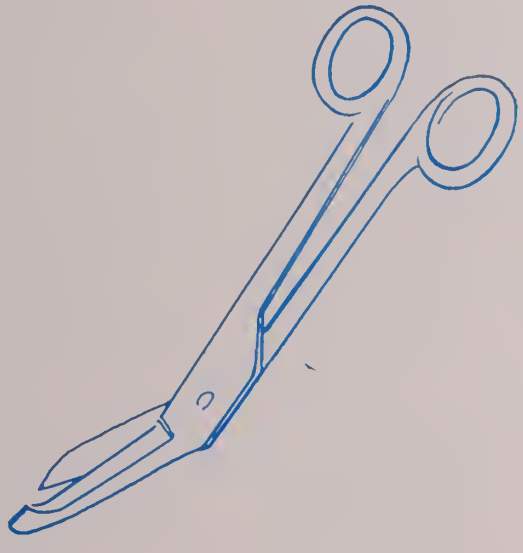
Proceed with caution when you are the operating surgeon who will be the first to investigate a

patient's back problem. If, on the other hand, you are the surgeon who needs to consider the second or third operative procedure as a part of multiple operative procedures on a patient's back, likely the decision of care will resolve around a surgical procedure of considerable magnitude. Success in eliminating pain with this type of patient problem may be extremely difficult, if not impossible, since there may be a "fixed pain pattern" in the patient's sensorium.

Summary

When surgery is contemplated, back problems should be approached with caution over a prolonged period of office visits and patient contacts so that all of the factors mentioned can be satisfactorily resolved in the operating physician's mind.

Dr. Miller, 1000 N. W. 17th Street, Miami 33136.



Treatment of Acute Lumbosacral Strain

ROBERT J. PFAFF, M.D.

Acute lumbosacral strain is a conjectural term. In itself, it is not a pure diagnosis, but within its scope encompasses any painful affliction of the back. This time-honored overworked and much abused diagnosis connotes a condition residual within the back, usually as a result of trauma, which results in pain and muscle spasm and is occasionally accompanied by painful radiation into one or both of the lower extremities.

The medical profession is divided into two types—the "lumpers" and the "splitters." To the lumpers, acute lumbosacral strain would mean any painful back condition as a result of alleged injury which should yield to conservative management but may progress to the resistant stage, thereby necessitating the change of diagnosis to the term "ruptured disc." This, in turn, immediately implies the eventual necessity for surgical correction and, therefore, carries a more guarded prognosis. The splitters, on the other hand, would divide this term into a multitude of smaller conditions such as tears of the various muscles of support of the lumbosacral area, together with sprains of the iliolumbar ligaments, sacroiliac sprain, facet syndrome, painful arthritis of the lumbar spine, sacralization and lumbarization of the lumbar vertebrae, degeneration of lumbar discs and tears of the annular ligament of the intervertebral discs with or without tissue sequestration of the nucleus pulposus. Such refined diagnoses are an attempt to unscramble the various terms in use in current medical literature, an attempt to bring some order and reason to an otherwise chaotic nomenclature.

Pathomechanics

In order to treat the painful conditions of the back, a minimum of the pathomechanics of the low back should be reviewed before any logical course of treatment can be outlined and be made comprehensible.

The architecture of the human spine has undergone few evolutionary changes. In ascending the evolutionary scale, changes occur in both the size and the massiveness of the lumbar vertebrae; there is a migration of the pelvic structures to form a closed ring, as one sees in man. The lumbar facets, however, remain designed for bearing weight in a horizontal plane, thus achieving antigravity interlocking of the facets. In this manner, bony stability of the spine results. In the vertical plane, the facets become obliquely placed and this bony stability is lost. Antigravity stability is then relying solely on cartilaginous and ligamentous integrity. The annulus of the intervertebral disc has concentric rings of elastic tissue placed at right angles to each other. When the spine is in a horizontal position, these rings will resist distraction, lateral deviation and rotational forces upon the spine. For this purpose they were designed.

No built-in mechanism exists to prevent compression of the intervertebral discs when the spine is in a vertical position, as in the biped. This vertical compression of the discs produces posterior degeneration of the annulus and is augmented by the postural lumbar lordosis of the biped. The psoas major muscle tends to increase this lordosis by its attachment from the transverse processes of the lumbar vertebrae to the lesser trochanter of the

femora. This is particularly true in the middle-aged person in whom hip flexion contractures have developed from the sitting habits of today. Stretching and incompetency of the abdominal muscles result from pregnancy, obesity, abdominal operations, disuse atrophy following corsets, girdles and other foundation garments and complete disregard of abdominal muscles in the overfed persons of any age. Most exercise and physical education programs tend to restore muscle strength and integrity to all extremities and the extensors of the spine, almost totally ignoring the fact that unless the ratio of strength between the erectors of the spine and those of the abdominal muscles remains at a constant 3:1, the abdominal muscles cannot withstand deforming factors of the musculus erector spinae, further resulting in increased lordosis. The sacrum then assumes a more horizontal plane and the lumbosacral angle increases.

Disc Compression Degeneration

If one could accept the fact that there is no "normal" lordosis, either in the lumbar or in the cervical spine, and that these so-called secondary postural curves which anatomy books teach are the result of early deformations of the spine as a result of holding one's head up in an erect position as a newborn and in attempting to emulate the primate position while an infant, then the process of degenerative disc disease can be understood. Let me reiterate: there is no built-in mechanism to prevent or retard disc compression degeneration. Intervertebral discs, therefore, usually in the third decade of life, will begin showing degenerative changes with narrowing of disc spaces and subluxation of facets, and we begin to see postural lordosis and backaches. These changes can be seen roentgenologically as disc narrowing, subluxation and osteophyte formation in and about the facets, spinal osteophytosis representing anterior annular ruptures in younger persons and posterior annular ruptures in older persons with or without nerve root impingement and tissue sequestration.

In the later fifth and sixth decades, abortive reparative changes in muscle, bone and cartilage of the spine occur within these areas of stress. These changes can later be interpreted as osteoarthritis, osteophytosis, spondylosis and increased sclerosis in and about the facets and sacroiliac joints (osteitis condensans ilii). With osteoporosis and the reduced resistance of vertebral bodies to withstand the pressures of the intervertebral discs, the discs, instead of rupturing externally, tend to rupture into the centra of the vertebrae, now the path of least resistance, and biconcaving of the vertebrae results. This, then, constitutes a process of degenerative changes following assumption of an erect position in a spine which architecturally was designed for the horizontal functional plane. Lordosis, either in the cervical or lumbar area, is not "normal," but is normally seen in all age groups. Hence, all mankind is heir to this process of senescence.

Pain is the body's first line of defense, calling for cerebral awareness to an area of injury. In the typical case of acute lumbosacral strain, there is usually a strain-caused or forceful lordosis of the lumbar spine, giving a sensation of localized pain which subsides to a dull, generalized ache. If activity ceases, the dull pain subsides or remains unchanged, depending upon the magnitude of injury received. If activities continue, pain increases and protective muscle spasm ensues, forcing cessation of all activity. This "spasm" is involuntary and is intended to preclude any use of the injured area which might increase further damage and to ensure rest to the part. The patient assumes a "flat-backed" position with obliteration of the lumbar lordosis. This is not spinal flexion, as can be verified by a lateral roentgenographic view of the lumbar spine, but is the spine's position of protective rest. It is in this position the patient frequently presents himself to the examiner.

Treatment

Enforced rest is essential; inflammatory response to injury is held to an irreducible minimum and healing can be initiated. The contour position in bed is most helpful for this purpose. It neutralizes the pull of the psoas major muscle on the low back, and by 30 degree elevation of the head of the bed the lumbar lordosis is further reduced. Protective spasm can thus subside, and with it the painful awareness of injury. It has become popular to use pelvic traction to maintain this position and enforce rest.

Pelvic traction immobilizes the pelvis and the trunk. If traction force is placed at a 45 degree angle to the frontal plane of the trunk, lordosis is further reduced. The concept that this traction opens up the interspaces of the lumbar area and allows reduction of any sequestrated nuclear material to re-enter the annulus is not tenable. The traction does allow rest in a protective position and

should be maintained undisturbed until the pain and spasm subside, usually 72 to 96 hours.

During this initial period there is a popular tendency to use the various modalities of physical therapy in the form of heat, massage and exercise. The various forms of thermal heat, including popular ultrasound, relax muscle, dilate arterial blood vessels and increase lymphatic flow. This effect is achieved to a maximum after only 10 to 15 minutes; thermal heat application beyond this length of time should be avoided, as excessive tissue-induced heat can cause local edema and thermal damage to the tissues.

The use of electrical fatiguing of muscle (medcolator) also should be limited to a few minutes, for once the muscle in spasm is fatigued and rendered nonfunctional, further stimulation is injurious. The effect is short. Muscle recovers rapidly, and the use of electrical fatiguing is open to debate.

Chemical muscle relaxants are presently popular. These medications act upon the central nervous system or at the myoneural junction to inhibit the contraction of the striated muscles and minimize or eliminate painful muscle spasms. In this form of therapy, sufficient dosage should be given over the first day or two of treatment to produce inhibition of the extraocular muscles and a slight blurring of the patient's vision. This is the sole clinical indication that generalized response to the medication has been achieved, and at this level the dosage can be slightly reduced with the assurance that a clinical response is being maintained. The dosage varies for each patient.

The body's reaction to injury starts with vascular dilation, diapedesis, increase in intercellular fluid and protein, leukocytic infiltration and increase in lymphatic and venous return from the injured area. This is a standard response to injury within the body. It can progress to the chronic forms of tissue reaction, characterized by round cell infiltration and, later, fibroblastic proliferation and scar tissue formation. It is the subacute and chronic manifestations which must be precluded, and here the use of high doses of aspirin for its antiphlogistic activity, corticosteroids and the chemical anti-inflammatory agents find their usefulness. The route of administration of these drugs is by choice; pharmacological, biochemical and histochemical responses are identical. Articles advocating tissue infiltration, epidural deposition, intrathecal injection and injection of steroids within the nucleus pulposus itself concomitantly performed with discograms are to be found in the medical literature. Steroids reduce the inflammatory response in the injured area of the back; hence, short term corticosteroid therapy has its place in reducing the inflammatory radiculitis of the sciaticas.

So far, it would seem that absolute, enforced bed rest over a three to five day period with the spine placed in a position of maximal rest (contour position) with administration of analgesics to allay pain and muscle relaxants to reduce local spasm would be the most efficacious means of treating lumbar strain. If after five to seven days of this absolute rest severe pain and spasm remain, particularly in the presence of radiculitis and a persistent, positive straight-leg raising test, reduction in deep tendon reflexes and persistent hypalgesia of known skin dermatomes and muscle weakness of known myotome distribution, one then assumes a persisting irritation to the nerve roots at a given spinal level and considers a herniated nucleus pulposus (tissue sequestration) of sufficient size and location that further conservative management would be questionable. A myelogram may be utilized to confirm the diagnosis, to ascertain the actual spinal level of involvement, to rule out the possibility of multiple level involvement and to determine the size of the sequestration. The size has a direct correlation with the degree of operative difficulty and permanent nerve root damage to be anticipated.

Most patients with "acute lumbosacral strain" will respond to conservative measures. Conservative treatment does not end with the patient standing at bedside, relatively free of pain and spasm. No tissue in the body completely heals itself in five to seven days. During the remaining healing period, protection from injudicious use of the back and all abuse of the lumbar spine should be insured. This takes an average of six weeks. With this in mind, the patient may then be given a corset or brace support for the back, depending upon the desires and suitability of the individual patient. The support should be fitted to reduce lumbar lordosis and to maintain the spine in a relatively flat-backed position. A Williams' flexion brace, or the use of a standard lumbosacral corset with four rigid stays fashioned in the form of the figure "J," rather than in the shape of an "S," is prescribed. The patient should be made to contour to the corset, rather than the corset made to contour to the patient. This reduces the patient's residual lordosis, rather than to build his residual

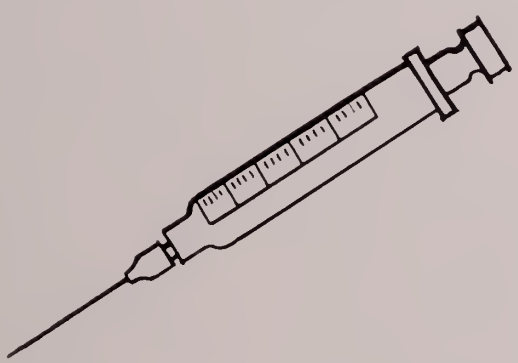
lordosis into the corset. The patient is then ready to go home.

Counseling

Proper counseling of the patient prior to his leaving the hospital can help him avoid much of the pain that may occur soon after he returns home. This counseling should include an admonition to avoid the lordotic position of the marital act. The patient should not be discharged from follow up until he no longer needs a brace or corset. Within 10 days, and certainly at the end of three weeks of brace support to any muscle, disuse atrophy ensues, and it is not until this muscle atrophy has been treated and normal muscle strength and endurance have been returned to the trunk that the patient can be assumed to have returned to his normal preinjury state. Here, exercises are of prime importance. The gradual, progressive removal of the corset for increasing periods of time during the day not only will help restore muscle strength and endurance, but will minimize atrophy and loss of muscle tone. When good trunk muscle strength and endurance have returned, the patient can return to employment. Here, in many situations, medical treatment ceases, but should not. It is the burden of the physician to try to prevent or minimize further attacks of the painful low back episode, hopefully preventing a future tissue sequestration necessitating surgery.

Exercises to restore the proper alignment of the trunk should be stressed at this point. The exercise program should be designed to restore good abdominal muscle tone, strength and endurance; reduce the lumbar lordosis; reduce the lumbosacral angle and the forward tilting of the pelvis; restore strength and integrity to the hamstring muscles of the thigh, which provide a counterforce to forward tilting of the pelvis; stretch out the psoas major muscle and the residual flexion contractures of the hip and restore the normal strength ratio of 3:1 between the musculus erector spinae and the musculus flexor spinae. It is through this restoration that the patient becomes most resistant and impervious; without this restoration, further attacks can be prognosticated.

Dr. Pfaff, 1600 Lakeland Hills Boulevard, Lakeland 33802.



Osteoporosis in the Aged Spine

JAMES L. WEST, M.D.

Osteoporosis is a condition of middle and later life in which the composition of bone is normal but there is too little of it—more common in Anglo-Saxon women. The bone structure is weakened and can be easily injured, altered or fractured with or without trauma from the stress of weight bearing alone. There is an increased frequency of fractures of the lower end of the radius, the spine and the neck of the femur. Osteoporosis may also be responsible for pain due to stress and strain without clinical evidence of fractures. Patients who present themselves for treatment of this condition because of pain or fractures are frequently ill-nourished and have complicating conditions pertinent to this age group, such as cardiac, renal, mental and gastrointestinal disturbances.

Etiology

Many theories have been proposed over the years as to the cause of osteoporosis. These have included defects in matrix production associated with decreased anabolism; altered calcium intake causing low serum calcium, which in turn alters the parathyroid gland resulting in more reabsorption of calcium from the bone; alteration of calcium crystallization on collagen fibers; the effect of aging, and inactivity itself. Osteoporosis, therefore, appears as a different process to the clinician, radiologist, histologist, biochemist and molecular biologist. The clinician must speak in general terms, such as increasing bone reabsorption or decreasing bone formation. The etiology of osteoporosis remains an enigma. It is simply stated: with the advance of age, reabsorption of bone outstrips the process of repair and bone formation and rarefaction osteoporosis ensues.

Symptomatology

The presenting picture may vary from that of a patient with a stooped, round-back deformity who is barely able to ambulate and has excruciating pain following any skeletal exertion to that of the active, ambulatory patient with a straight spine who has onset of back pain following some vigorous physical activity or trauma. In the former, the pain has usually developed over a period of many months, gradually increasing to a crescendo that necessitates hospitalization and prolonged care. In the latter, the patient is usually unaware of the pre-existing problem until the sudden onset of acute pain. The pain is typically radiating and rarely radiates into the leg in the manner of pain caused by nerve root pressure. In the case of the patient who has such a severe involvement, hospitalization is necessary; ileus and constipation are frequently present, the appetite is diminished, the urinary output frequently decreases and there is need for pain relief.

X-Ray Findings

A general washed-out appearance of diminished bone density is present early. Ballooning of the intervertebral disc occurs as the process continues, ultimately resulting in the "fishtailing" or "codfish vertebra." Only a few vertebral bodies are involved early in the course; the entire spine may later be involved. The next change to occur is actual vertebral collapse which varies in degree. X-rays of the metacarpals are considered a more foolproof method of diagnosing the osteoporosis by some observers, although in a clearcut case this is hardly necessary. Many efforts have been

Table I. — Pertinent Considerations in Diagnosis of Osteoporosis

History:

1. Activity
2. Age
3. Duration of pain
4. Quality
5. Menstrual history
6. Posture
7. Decrease in height
8. Round-shoulder deformity
9. Food intake
 a) Calcium
 b) Protein
10. Medication, corticosteroids

Physical Examination:

1. Posture
2. Motion of spine
3. Bone tenderness
4. Gait
5. Height
6. Weight
7. Negative motor or sensory changes neurological
8. Systemic—gastrointestinal disease

made to standardize the x-ray examination to determine the exact amount of mineral density, but these have met with repeated failure.

Differential Diagnosis

A number of conditions other than osteoporosis will produce rarefaction and pathological fractures of the spine in the aged. These must always be considered before arriving at a diagnosis. The most common are metastases from malignant tumors and multiple myeloma. Primary tumors will produce the same findings, but on a localized basis. Hyperparathyroidism, polycythemia veru, hemolytic anemia, ankylosing spondylitis and other conditions may cause vertebral collapse but are relatively uncommon as compared to the instance of osteoporosis in aged persons.

It is the burden of the treating physician to rule out other conditions, since the diagnosis of osteoporosis is necessarily made by exclusion. If the patient is over 65, chances are the diagnosis is osteoporosis. If the patient is under 55, one must carry out an exhaustive diagnostic workup before concluding that osteoporosis is the offender. Previous mention that osteoporosis is more common in Anglo-Saxon women does not exclude its appearance in men. Metastatic carcinoma of the prostate must be included in the differential diagnosis in this group. Table I includes some of the more pertinent diagnostic considerations.

Laboratory Tests

Laboratory tests for osteoporosis include complete blood count, sedimentation rate, urinalysis, Bence Jones protein reaction, serum protein, both total and albumin/globulin ratio, serum calcium and phosphorus, alkaline phosphatase, acid phosphatase, Sulkowitch 24 hour urine test for calcium and x-rays of the spine, skull, chest and other areas as indicated. Sternal or iliac biopsies or direct vertebral biopsies are rarely needed. In order to rule out the presence of multiple myeloma, these laboratory tests need to be done, and they will usually show either one or all of the following findings: Alteration of the total protein with an increased globulin, reversal of the A/G ratio, positive Bence Jones protein, increased sedimentation rate, increased alkaline phosphatase, increased calcium secretion and lytic areas on skull films.

If there is any doubt concerning the diagnosis of multiple myeloma, a sternal or iliac marrow biopsy is indicated. Metastatic lesions can be ruled out by the history, normal results otherwise of physical examination and a negative reaction to the alkaline phosphatase test. A direct vertebral biopsy can be done, but this rarely will be necessary.

Treatment

Treatment of patients with osteoporosis is divided into two phases: treatment of the bone weakness and spinal fractures which are responsible for the pain and deformity, and treatment of the causative factor and other related general problems.

One must admit that to date the treatment of the basic pathology has been wanting. Nevertheless, there are some bright spots from a therapeutic standpoint, and one should forge ahead.

Initially, fractures or weakened bone should be splinted in such a manner that the patient can be as ambulatory and active as possible. It is necessary to immobilize injured and painful areas, such as compression of the spine; on the other hand, this immobilization should not be so extensive or rigid that the patient cannot be ambulatory. Activity in the elderly is of well known therapeutic value and even more so in treatment of this particular problem.

Some years ago, estrogen therapy was recommended as the accepted treatment for osteoporosis. As time has passed it has been determined in the



Figure 1

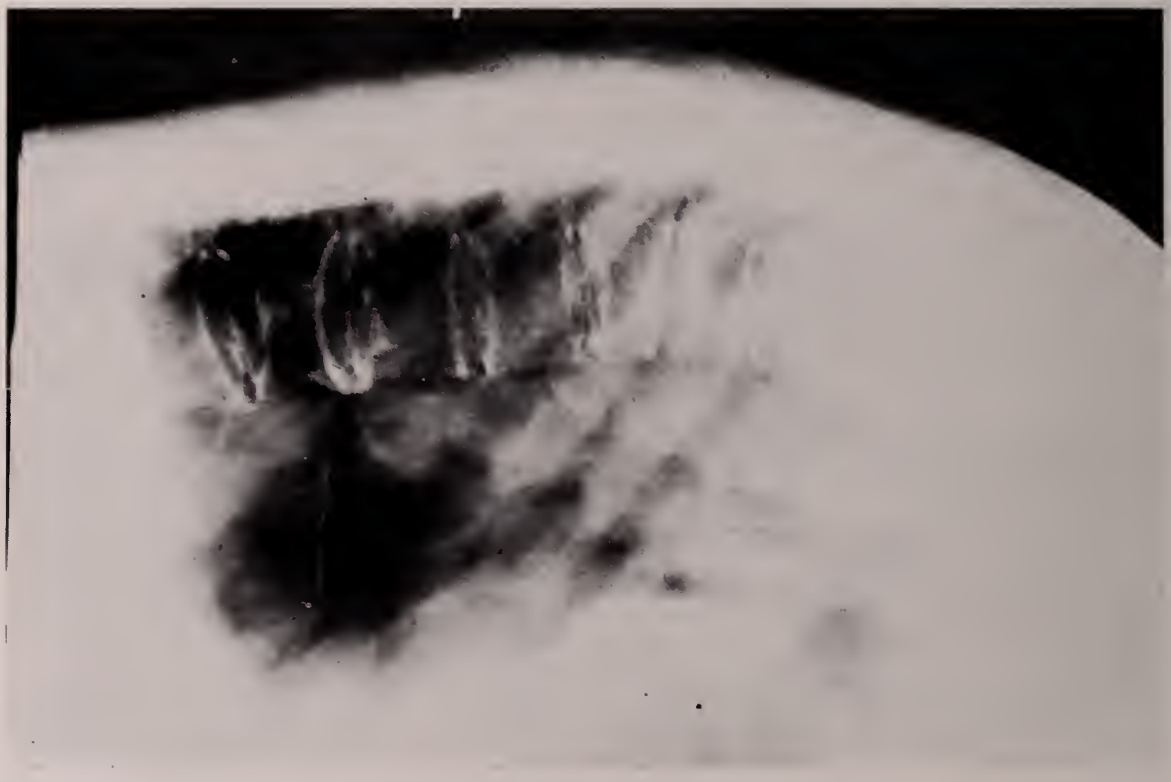


Figure 2

laboratory that estrogen therapy is of questionable value.

Estrogen, of course, is beneficial and indicated in postmenopausal states and might well serve to prevent the formation of osteoporosis. Anabolic agents, such as testosterone and its varied derivatives, including methandrostenolone, are beneficial. In conjunction with a high protein diet, these serve to establish a healthy matrix. Other observers have established that a normal or high calcium intake in an ambulatory, active patient is of value in ceasing or reversing the drain of calcium from the bone. Further research has been productive in pointing up the fact that a fluoride intake of 0.50 mg./kg. of body weight per day, or roughly 50 to 100 mg. day, is beneficial in the formation of fluoroapatite, which is a substitute for the hydroxyapatite. This results in the formation of an altered bone crystal that has different physical properties from those of the normal bone and is less subject to resorption.

As far as the treatment of osteoporosis is concerned, there is no short cut. One must first treat the symptoms with bedrest, bracing, pain medication and sedation as well as treating the concomitant diseases that are present in the aged. Attention then must be turned to anabolic therapy, increased calcium intake, with or without the addition of estrogen to mask the masculinizing effects of the anabolic agent, and providing for the general well-being of the patient. It would seem that in light of recent research, fluorides should be considered strongly and added to the therapeutic program. A high protein diet and vitamin therapy will depend upon the individual needs and will do no harm if used in all cases.

References

1. Rich, C., and Ivanovich, P.: Response to Sodium and Fluoride in Sevcre Primary Osteoporosis, Ann. Int. Med. 63:1069-1074 (Dec.) 1965.
2. Cass, R. M.; Croft, J. D. Jr.; Perkins, P. et al: New Bone Formation in Osteoporosis Following Treatment With Sodium Fluoride, Arch. Int. Med. 118:111-116 (Aug.) 1966.
3. Symposium on Osteoporosis, Dr. Robert P. Haney, moderator. Combined program of Orthopaedic Research Society and American Academy of Orthopaedic Surgeons. Abstracted J. Bone & Joint Surg. 48a:1009 (July) 1966.
4. Jowsey, J., and Raisz, L. G.: Experimental Osteoporosis and Parathyroid Activity, presented at the 11th Annual Meeting of the Orthopaedic Research Society, New York, N.Y., Jan. 8-9, 1965. Abstracted in J. Bone & Joint Surg. 47a:109, 1965.
5. Nicholas, J. A., and Wilson, P. D.: Osteoporosis of the Aged Spine, Clinical Orthopaedics 26:19.

Dr. West, 1900 Ninth Street South, St. Petersburg 33701.



Figure 3



Observations on Financing Medical Care

The financing of medical care since the beginning of the profession has been based on obligation of the patient to pay a fee for service and obligation of the physician to provide quality medical care. Services available to all, rich and poor alike, has been a guiding principle of the medical profession.

Government responsibility to provide for the poor was formalized by the poor laws of Elizabeth I, and Bismarck first required industry to provide health insurance for low income workers.

In the past 100 years, government-supervised tax-supported health care plans of all types have been tried by various countries for the avowed purpose of providing better medical care for more people more economically.

A review of the historical development of government medical plans in other countries reveals:

1. Economy in medical care has never been achieved by government control, and costs have always greatly exceeded original estimates.
2. Quality of medical care has not been improved by government control except in underdeveloped countries, but better dissemination of medical care has often been achieved especially in poor and depressed areas.
3. A government medical care program has never completely satisfied the medical desires of the people, especially in sophisticated societies, and has often reverted to a basic minimum of health care guaranteed by government leaving to the individual the choice of electing and financing additional health care services.

Present Environment

Amazing scientific advances in the past 30 years have vastly improved the possible benefits from medical care and greatly increased the demand for medical services. Attendant to the improved benefits and demand, health care costs and expenditures have increased.

Reacting to the increasing costs and demands for health care, the federal government of the United States has recently assumed obligation to the aged to provide hospital care and aid in insuring for physicians' services. In cooperation with the states, the federal government has assumed the major portion of costs for providing comprehensive health services to the poor requiring quality and equality of medical care for eligible recipients.

Recommendations

Experiences of health care programs in other countries should aid in the development of methods of financing health care that might avoid the pitfalls of excessive cost, decrease in quality and public dissatisfaction.

Therefore, the following recommendations are made as guidelines for development of methods for the financing of health care:

1. Methods of financing the costs of shelter and technical services (hospitals, extended care facilities and nursing homes) should be entirely separate from the financing of physicians' services and without interdependence.
2. The insurance method should be used for financing the costs of physicians' services wherever rendered, with government paying the premium for those government-

assumed obligations. Voluntary insurance subscribed by individuals or through business and industrial groups should be encouraged and government should not assume obligation for those who can provide for themselves.

3. The individuals involved (patient and physician) should be expected to fulfill responsibilities in the insurance method of financing medical care whether the premium is paid by the individual, business or government. Physicians must fulfill responsibilities in utilization review and quality control in order to preserve freedom in prescribing medical care. Patients must consider their medical insurance an aid in fulfilling their individual financial responsibility for services received in order to maintain their freedom to elect those medical services they desire.

H. Phillip Hampton, M.D.
Tampa

Medicine and Religion

In 1963 the American Medical Association established a Committee on Medicine and Religion. Top billing for medicine perhaps reflected historical antedating, not importance. The use of the words medicine and religion derive their meanings from the tradition, culture and struggles of the peoples in the societies analyzed. Primitive medicine treated light ailments by drugs, special diets or exhortations. Serious ailments were explained by magic or religion, placing the primitive physician as a priest and magician as well. Medicine and religion primitively were intertwined; man or demon had harmed a patient or a Deity had sent disease as a punishment for sin.

The Greek world was a world of the healthy and the sound——disease was a curse because it removed man from perfection and he was thus inferior. The Greek physician was a craftsman, receiving his training as an apprentice and practicing his—note the term—art while wandering. These traveling physicians emigrated to Rome and because they were valuable for treating the wounded of the Roman army, Julius Caesar in 46 B. C. conferred Roman citizenship upon them.

In the Greek era the priests were no longer physicians, but became the ideological spokesmen for the governing class, thus reactionary, while the prophets, springing essentially from the peasantry, were the revolutionaries. This is the basic Judaic tradition—the challenge to orthodoxy which covers injustice, rule which stifles expression and rebelliousness against exploitation. The Greeks could accept society with the philosophy of Plato for a "Republic" which maintained slavery, while the Jews could produce the "Messiah," the social revolutionary, the heretic, Jesus. And his heresy? —freedom for land and for liberation of the slaves.

Following this, the Judeo-Christian approach to the ill, the maimed, became consideration for those so afflicted as grace, sanctification, love of God. Martyrs are "witnesses" who by sacrificing themselves instruct others, an interesting tradition not monopolized by Jews or Christians as Buddhist self conflagration in Vietnam epitomizes.

With the acceptance of Christianity as the official religion of the Roman Empire by Constantine came hospitals, medical schools (Salerno, 1000 A.D.) and laws regulating the practice of medicine. From this stage on it has been difficult for the physician to accept that his position in society is not determined by him but by the society he is serving.

With linguistic obfuscation, the physician today tolerates the statement that his is an art not a science. This is not just an accidental pabulum, but a device of orthodoxy. Art is the employment of skills for purposeful accomplishments. Science is systematized knowledge, a search for truths and laws which can be demonstrated by induction, experimentation or observation. Leaders defend orthodoxy while scientists must be innovators, revisionists, dissatisfied with the status quo—in short, heretics. Religion, institutionalized, sectarianized, divisive, can defend a flat nonrotational earth, denial of earlier organic species than Adam, space and more than a solar system, but medicine must be a science dedicated to a world which must still be found. A physician must be a scientist, and to be such he will become a heretic, albeit religious in the fundamental sense of communion with people and nature.

Harry E. Beller, M.D.
Miami

DORSEY "FLU-GRAM"

DON'T BE LULLED BY RELATIVE LACK OF FLU LAST WINTER. THIS WINTER BE PREPARED: WHEN THE COMPLAINTS ARE COUGH AND CONGESTION, YOU CAN RELIEVE THESE SYMPTOMS WITH TUSSAGESIC TABLETS. ONE TIMED-RELEASE TABLET AT MORNING, MIDAFTERNOON AND BEDTIME BRINGS UP TO 24 HOURS' RELIEF FROM TROUBLESOME COUGH AND STUFFED AND RUNNY NOSE. TUSSAGESIC IS THE FAMOUS TRIAMINIC FORMULA, PLUS THREE OTHER PROVED CONSTITUENTS. MAKES PATIENTS MORE COMFORTABLE. FAST. ASK YOUR DORSEY REPRESENTATIVE FOR SUPPLY OF STARTER SAMPLES, OR IF FLU IS ALREADY EPIDEMIC, PHONE COLLECT. SEE BELOW.

each

Tussagesic®

timed-release tablet contains:

Triaminic® (phenylpropanolamine hydrochloride 25 mg., pheniramine maleate 12.5 mg., pyrilamine maleate 12.5 mg.)	50 mg.
Dextromethorphan hydrobromide	30 mg.
Terpin hydrate	180 mg.
Acetaminophen	325 mg.

Dosage: Adults—1 tablet, swallowed whole to preserve timed-release feature, in morning, midafternoon and at bedtime. Side effects: Occasional drowsiness, blurred vision, cardiac palpitations, flushing, dizziness, nervousness or gastrointestinal upsets. Precautions: The patient should be advised not to drive a car or operate dangerous machinery if drowsiness occurs. Use with caution in patients with hypertension, heart disease, diabetes or thyrotoxicosis.

DORSEY LABORATORIES
a division of The Wander Company
Lincoln, Nebraska 68501

clip and file under "flu"

For relief of "flu-like" symptoms
Tussagesic timed-release tablets

PHONE COLLECT

For emergency starter samples
to Keith Sehnert, M.D.
Medical Director
(402) 434-6311

Fast delivery by your Dorsey Representative



in sinusitis, colds, U. R. I.

Dimetapp® Extentabs®

(Dimetane® [brompheniramine maleate], 12 mg.;
phenylephrine HCl, 15 mg.; phenylpropanolamine HCl, 15 mg.)

up to 10-12 hours clear breathing on one tablet

It's clear—Dimetapp lets your "stuffed-up" patients breathe easy again. Each hard-working Extentab brings welcome relief from the stuffiness, drip and congestion of upper respiratory conditions for up to 10-12 hours. Yet, patients seldom experience drowsiness or overstimulation. Its key to success is the Dimetapp formula: Dimetane (brompheniramine maleate)—along with phenylephrine and phenylpropanolamine, two time-tested decongestants. They get the job done...in a hurry.

Contraindications: Hypersensitivity to antihistamines. Not recommended for use during pregnancy. **Precautions:** Until patient's response has been determined, he should be cautioned against engaging in operations requiring alertness. Administer with care to patients with cardiac or peripheral vascular diseases or hypertension. **Side Effects:** Hypersensitivity reactions including skin rashes, urticaria, hypotension and thrombocytopenia have been reported on rare occasions. Drowsiness, lassitude, nausea, giddiness, dryness of the mouth, mydriasis, increased irritability or excitement may be encountered. A. H. ROBINS COMPANY, Richmond, Virginia 23220
Dosage: 1 Extentab morning and evening. **Supplied:** Bottles of 100 and 500.

A·H·ROBINS

Preludin® phenmetrazine hydrochloride



For complete details,
please see full
Prescribing Information.

helps keep calories at arm's length

Preludin is indicated only as an anorectic agent in the treatment of obesity. It may be used in simple obesity and in obesity complicated by diabetes, moderate hypertension, or pregnancy. For use in pregnancy, see Warning.

Dosage: One 25 mg. tablet b.i.d. or t.i.d. Or one 75 mg. Endurets® prolonged-action tablet a day, taken by midmorning.
Contraindications: Severe coronary artery disease, hyperthyroidism, severe hypertension, nervous instability, and agitated prepsychotic states. Do not use with other CNS stimulants, including MAO inhibitors.



Warning: Do not use during first trimester of pregnancy unless potential benefits outweigh possible risks. There have been clinical reports of congenital malformation, but causal relationship has not been proved. Animal teratogenic studies have been inconclusive.
Precautions: Use with caution in moderate hypertension and cardiac decompensation. Cases involving abuse of or dependence on phenmetrazine hydrochloride have been reported. In general, these cases were characterized by excessive consumption of the drug for its central stimulant effect, and have resulted in a psychotic illness manifested by restlessness, mood or behavior changes, hallucinations, or delusions. Do not exceed recommended dosage.
Side Effects: Dryness or unpleasant taste in the mouth, urticaria, overstimulation, insomnia, urinary frequency or nocturia, dizziness, nausea, or headache. (B)R46-560-A

Geigy Pharmaceuticals, Division of
Geigy Chemical Corporation, Ardsley, N.Y.

Under license from
Boehringer Ingelheim G.m.b.H.

even in ulcerative colitis...

characterized by:
—diarrhea, cramps, tenesmus
—bloody, mucoid, purulent stools



LOMOTIL® tablets/liquid

Each tablet and each 5 cc. of liquid contains:
diphenoxylate hydrochloride 2.5 mg.
(Warning: May be habit forming)
atropine sulfate 0.025 mg.

controls diarrhea

In six published studies[1-6] detailed results are given on the use of Lomotil in 111 patients with chronic ulcerative colitis. They show that Lomotil gave satisfactory to "excellent" control of diarrhea in more than two-thirds of these patients. As the disorder advances and destroys bowel musculature, the motility-lowering action of Lomotil, understandably, has less effect.

The successful use of Lomotil in a disorder as exceedingly difficult to treat as moderate ulcerative colitis emphasizes again its unsurpassed antidiarrheal effectiveness in these more common conditions:

- **Gastroenteritis**
- **Acute infections**
- **Spastic colon**
- **Drug induced diarrhea**
- **Functional hypermotility**

For correct therapeutic effect
Rx correct therapeutic dosage

Dosage: The recommended initial daily dosages, given in divided doses until diarrhea is controlled, are:

Children: Total Daily Dosage

3-6 mo. . . ½ tsp.*t.i.d. (3 mg.)
6-12 mo. . ½ tsp. q.i.d. (4 mg.)
1-2 yr. . . . ½ tsp. 5 times daily (5 mg.)
2-5 yr. . . . 1 tsp. t.i.d. (6 mg.)
5-8 yr. . . . 1 tsp. q.i.d. (8 mg.)
8-12 yr. . . 1 tsp. 5 times daily (10 mg.)
Adults: 2 tsp. 5 times daily (20 mg.)
or 2 tablets q.i.d.

*Based on 4 cc. per teaspoonful.
Maintenance dosage may be as low as one-fourth the initial daily dosage.

Precautions: Lomotil is a federally exempt narcotic preparation of very low addictive potential. Recommended dosages should not be exceeded, and medication should be kept out of reach of children. Should accidental overdosage occur signs may include severe respiratory depression, flushing, lethargy or coma, hypotonic reflexes, nystagmus, pinpoint pupils and tachycardia. Lomotil should be used with caution in patients with impaired liver function or those taking addicting drugs or barbiturates.

Side Effects: Side effects are relatively uncommon but among those reported are gastrointestinal irritation, sedation, dizziness, cutaneous manifestations, restlessness, insomnia, numbness of the extremities, headache, blurring of vision, swelling of the gums, euphoria, depression and general malaise.

1. Barowsky, H., and Schwartz, S. A.: J.A.M.A. *180*:1058-1061 (June 23) 1962. 2. Cayer, D., and Sohmer, M. F.: N. Carolina Med. J. 22:600-604 (Dec.) 1961. 3. Hock, C. W.: J. Med. Ass. Georgia 50:485-488 (Oct.) 1961. 4. Van Derstappen, G., and Vandenbroucke, G.: Med. Klin. 56:962-964 (June 2) 1961. 5. Merlo, M., and Brown, C. H.: Amer. J. Gastroent. 34:625-630 (Dec.) 1960. 6. Weingarten, B.; Weiss, J., and Simon, M.: Amer. J. Gastroent. 35:628-633 (June) 1961.

SEARLE *Research in the Service of Medicine*


at the site of infection
(where it counts)...

Ilosone® provides more antibacterial activity than any other oral erythromycin

Acid stable, better absorbed... Ilosone produces faster, higher, more prolonged blood levels, even in the presence of food[1-3]

Because it is the most active form of oral erythromycin, Ilosone can help assure consistently greater antibacterial activity at the site of infection. Ilosone produces peak antibacterial blood levels two to four times those of other erythromycin preparations.[1,2] Not only are these levels attained earlier, but they are maintained for much longer periods. Even the presence of food does not seem to affect the activity of Ilosone.[1,3]

In the treatment of patients with bacterial infections susceptible to erythromycin, Ilosone has compiled an excellent therapeutic record. Since it exerts its greatest activity against gram-positive organisms, it is particularly useful in common respiratory and soft-tissue bacterial infections. Ilosone kills—not merely inhibits—streptococci, pneumococci, and more strains of staphylococci than any other macrolide antibiotic. This bactericidal action, coupled with the high antibacterial levels attained, makes Ilosone especially valuable in patients with low host resistance, such as infants, debilitated individuals, and diabetics.

Ilosone has shown no cross-resistance with penicillin and may be effective against organisms that have become resistant to that agent. Despite its high antibacterial activity, Ilosone has demonstrated a low incidence of side reactions. Blood dyscrasias, ototoxicity, and tooth staining have not been observed. Infrequent cases of drug idiosyncrasy, manifested by a cholestatic jaundice, have occurred, but there have been no known definite residual effects.

Now available:
New! Ready-mixed Ilosone Liquid 125! (Contains erythromycin estolate equivalent to 125 mg. erythromycin base per 5-cc. teaspoonful.)

700970

Ilosone®
Erythromycin Estolate

Lilly

(See next page for prescribing information.)

Ilosone®/ the most active oral form of erythromycin

Description: Ilosone is the most active form of oral erythromycin that has been developed. Because it is stable in acid, well absorbed, and excreted in lesser amounts in the bile, it provides faster, higher, and longer-lasting levels of antibacterial activity (ABA) in the serum, even when taken with food, than do comparable doses of erythromycin.

Indications: Ilosone is indicated in infections caused by microorganisms sensitive to its action (especially staphylococci, hemolytic streptococci, and pneumococci). The drug is therefore useful in a high proportion of bacterial diseases encountered in clinical practice and particularly in the treatment of bacterial infections of the upper and lower respiratory tract and soft tissues.

In the treatment of acute bacterial pharyngitis and tonsillitis, this antibiotic has promptly eradicated the bacteria (streptococci) and has produced a parallel prompt clinical improvement. There have been no group A beta-hemolytic streptococci resistant to this preparation. In beta-hemolytic streptococcus infections, treatment should be maintained for ten days to prevent the development of rheumatic fever or glomerulonephritis.

Erythromycin estolate has proved to be very effective in pneumococcus pneumonia and in acute bronchitis with pneumococci on culture. Bronchopneumonia and otitis media in children have responded well to its use.

The antibiotic has been used very successfully in staphylococcus infections. Good therapeutic results have been obtained in soft-tissue infections, abscesses, cellulitis, carbuncles, wound infections, and furunculosis.

In serious staphylococcus infections, erythromycin preparations should be used only in combination therapy with other antimicrobial agents. As is the case with any treatment regimen used in these severe conditions, surgical procedures should be performed when indicated, and large dosages of the antimicrobial agents should be employed. In this fashion, Ilosone has been effective in staphylococcus pneumonia, osteomyelitis, septicemia, empyema, and meningitis.

Multiple 500-mg. doses of the drug have also been useful in gonorrhea and syphilis. Since penicillin is the drug of choice for the treatment of syphilis and gonorrhea, erythromycin estolate should be employed for these infections only in patients with a history of penicillin allergy. Also, other infections due to susceptible bacteria in patients known to be hypersensitive to penicillin or other antibiotics may be considered for treatment with Ilosone.

Contraindications: Ilosone is contraindicated in patients with a known history of sensitivity to this drug and in those with preexisting liver disease or dysfunction.

Adverse Reactions: Data obtained from seven years' use of propionyl erythromycin ester and erythromycin estolate (Ilosone) indicate that hepatic dysfunction with or without clinical jaundice may occur during or following courses of therapy with the drug.

Changes in liver function tests in such cases have been indicative of intrahepatic cholestasis. The symptoms appear to be the result of a form of sensitization. The initial symptoms have developed in some cases after a few days of treatment but generally have followed one or two weeks of continuous therapy or several courses of the drug. Symptoms reappear promptly, usually within forty-eight hours, if the drug is readministered to sensitive patients. Eosinophilia was noted in peripheral blood counts. The findings readily subsided without apparent residual effects when treatment was discontinued. Recovery was delayed in one reported instance. The physician indicated in this case that either drug-induced jaundice or viral hepatitis may have been responsible for the findings.

In one clinical study involving ninety-three patients treated with the antibiotic, three cases of jaundice were observed and an additional eleven cases developed some changes in liver function tests. Three of the patients had abnormal liver function tests a second time on readministration of the drug.

Even though it is assumed that not all cases of jaundice have been reported, it seems clear that the number is small compared with the amount of drug that has been used. Reported cases have included persons in whom there had been administered other drugs known to be associated at times with hepatic side-effects and cases in which the presence of viral hepatitis or other disease may have been responsible for the findings. In some of the cases, associated gastro-intestinal symptoms simulated the colic of biliary tract disease. In other instances, clinical symptoms and results of liver function tests resembled findings in extrahepatic obstructive jaundice. It appears that the occurrence of jaundice after administration of Ilosone is infrequent, but further investigations are being made to estimate its incidence more accurately.

In those cases mentioned above in which jaundice appeared be definitely related to use of the drug, laboratory findings we characterized by increased direct-reacting bilirubin, elevat alkaline phosphatase levels, negative or weakly positive cephal flocculation and thymol turbidity tests, elevated serum glutam oxalacetic transaminase levels, peripheral eosinophilia, and no mal cholecystograms.

Individual idiosyncrasy seems evident since jaundice has n been reported in other patients taking prolonged courses of t medication. Patients with chronic infection have been given 1 to 2 Gm. of the drug daily for periods of two to six months, a patients with rheumatic fever have taken prophylactic doses 0.5 Gm. daily for two years without difficulty. In one group 144 patients who received the drug daily for two years, no jau dice was noted. It was of interest that members of six of the patients' families, who were not taking the drug, had episod of jaundice during the study period.

Transaminase and serum alkaline phosphatase levels we determined in a group of fifty-four adults and children who to 250 mg. of Ilosone daily for an average of sixteen months rheumatic fever prophylaxis. The results were compared wi those of a similar group of forty-four patients who received pe icillin. There were no cases of jaundice in either group. Elevati of SGPT and serum alkaline phosphatase levels during the cour of treatment was observed in one patient treated with Ilosor and in two patients treated with penicillin. Seven other patien in the group receiving Ilosone and four others in the penicill group showed elevations in one of the tests at some time durir administration of the drugs.

Very satisfactory therapeutic results, without toxicity, we reported in 102 pediatric patients who received short-term (te day) courses of Ilosone in the treatment of streptococcus infe tions. Results of liver function tests in these patients wer comparable to those in a similar control group who had receive penicillin.

Gastro-intestinal disturbances not associated with hepatic e fects are observed in a small proportion of individuals as a resu of a local stimulating effect of the medication on the alimenta tract; however, the normal intestinal gram-negative bacteri flora is not appreciably altered by erythromycin drugs.

Although allergic manifestations are uncommon with the u of erythromycin, there have been occasional reports of urticari skin eruptions, and, on rare occasions, anaphylaxis.

Administration and Dosage: Ilosone is administered orally.

Ilosone Pulvules®, Ilosone Liquid 125, Ilosone, 125, for Or Suspension, Ilosone Drops, Ilosone Chewable Tablets.

For infants and for children under twenty-five pounds of boc weight, the usual dosage is 5 mg. per pound every six hours; f children twenty-five to fifty pounds, 125 mg. every six hour (Tablets Ilosone Chewable should be chewed or crushed an swallowed with water.)

For adults and for children over fifty pounds, the usual dosag of Ilosone is 250 mg. every six hours.

For severe infections, these dosages may be doubled.

When larger doses are indicated, parenteral erythromyci therapy should be considered.

In the treatment of syphilis, the recommended total dosage 20 to 30 Gm. given in divided doses for a period of ten to fiftee days. Close follow-up of the patient is necessary since erythr mycin drugs have not had adequate evaluation in all stages syphilis. Examinations of spinal fluid are recommended as pa of the follow-up therapy.

For gonorrhea, 500 mg. four times a day for four days a recommended. In the treatment of gonorrhea, patients with suspected lesion of syphilis should have a dark-field examinatio before receiving antibiotics, and monthly serologic tests shoul be made for a period of three months.

How Supplied: Pulvules Ilosone, Capsules, N.F., 125 and 250 m (equivalent to base), in bottles of 24 and 100.

Ilosone Liquid 125, Oral Suspension, U.S.P., 125 mg. (equivale to base) per 5-cc. teaspoonful, in 60-cc. and pint-size package

Ilosone, 125, for Oral Suspension, N.F., 125 mg. (equivaler to base) per 5-cc. teaspoonful, in 60 and 150-cc.-size package

Ilosone Drops, 5 mg. (equivalent to base) per drop, in 10-cc.-siz packages, with dropper calibrated at 25 and 50 mg.

Tablets Ilosone Chewable, N.F., 125 mg. (equivalent to base in bottles of 50. [03276

References: 1. Griffith, R. S., and Black, H. R.: Am. J. M. Sc., *247*:69, 196 2. Griffith, R. S., and Black, H. R.: Antibiotics & Chemother., *12*:398, 196 3. Hirsch, H. A., Pryles, C. V., and Finland, M.: Am. J. M. Sc., *239*:198, 1960.

Additional information available to physicians upon request.
Eli Lilly and Company, Indianapolis, Indiana 46206.

Lilly

7009



Special Article

So You Want to Write an Article

JAMES O. BOND, M.D. and WILSON T. SOWDER, M.D.

At some time in the professional career of most of us, we will believe strongly that we have in mind *the* pearl of great literary prize which must be exhibited for the benefit of our colleagues. What shall be done?

The first impulse is to borrow the latest article written on the subject, plagiarize the bibliography, copy the organization and style, then tuck our two cents' worth somewhere into the body where it will rest impressively, surrounded by an obscure style, heavy jargon and esoteric neologisms.[1] Later perhaps, the article may be edited, ever so slightly, by our wives. They really are our poorest literary critics, that is, unless they love good prose writing as much as they love us.

As with most first impulses, this one should be forgotten.

In the event the thought persists that the article must be written, do read the most recent article on the subject, and as many more as you can locate. It may be you will find that your article has been written. On the other hand, you may find that the one you have in mind needs to be written. This is a most desirable situation, a first rate stimulus.

Now to get started. Listed are a few simple suggestions. They probably will not make you a master of scientific prose writing, but perhaps you will be stimulated to write more carefully than most medical authors appear to do today.

Don't start writing your article at the beginning. Start in the middle. Write as you would talk, naturally, easily, relaxed, in long hand preferably, covering what appears to you to be the heart of the subject. The beginning and ending of the article will take much more time, vast amounts of rewriting and a flash or two of genius. The beginning is the introduction of your subject, really the explanation to the reader why the article was written, and the ending is a summary in two or three short paragraphs of the material you have presented on the previous four or five pages.

When your thoughts have been transferred to paper, use scissors, paste and ingenuity liberally in organizing the material. Rarely will acceptable organization be achieved the first time around. Often the material will require reorganization as interesting and difficult as a jigsaw puzzle.

Hire a cliché and jargon "counter" unless you can readily recognize these needless words. Fearlessly and relentlessly strike out each group which adds nothing but useless newsprint. They may be resonant phrases, born of pure inspiration—only to you.

Go through the first or second draft of the article and underline each verb. Are they passive as in so many scientific presentations? If so, revise the sentences, changing a few—or all of them—to show action. Strong, active verbs keep the prose marching forward with banners flying.

Give each sentence the preposition test. Are there more than three in a sentence? If so, it is likely much too long, has too many dependent clauses and will surely lose your reader in a fog.



Losing readers in fogs is so commonplace that a "fog index" has been described. It goes like this.

1. Count the number of words in the passage. (In a long article, take several passages of 100 words each, spaced evenly through the article.) Divide the number of words by the number of sentences. You now have the average sentence length.

2. Count the number of words of three syllables or more per 100 words. Don't count words (a) that are capitalized, (b) that are combinations of short, easy words (like beekeeper, butterfly, shorthanded), or (c) that are verb forms having three syllables because of the addition of suffixes (-ed, -es, -ing). You now have the percentage of hard words in the passage.

3. Add factors 1 and 2 and multiply by 0.4. You now have the "fog index."[2]

Compare your rating in fog production with Thoreau or Mark Twain.

After struggling manfully with the manuscript, enlist the aid of an intelligent critic or put it away, completely out of your mind, for one month. You can qualify as a critic only after a

A COMPLETE BUSINESS SERVICE

FOR THE MEDICAL AND DENTAL PROFESSIONS

Professional Management

PM FLORIDA

233 Fourth Ave, N.E.
St. Petersburg, Florida
Phone 898-5074

1855 Hillview Street
Sarasota, Florida
Sarasota Phone 958-4493
4771 Bilmark
Ft. Myers, Florida
Ft. Myers Phone 936-3162

PROFESSIONAL MANAGEMENT since 1932 PM FOR PHYSICIANS AND DENTISTS

417 Executive Building
1175 N.E. 125th St.
Miami, Florida 33125
Dade Phone 751-2101
Broward Phone 523-0286

Affiliates of Black & Skaggs Associates
Battle Creek, Michigan

suitable period has elapsed. Ambiguities, awkwardness and grammatical guffaws will become apparent. You could never have found them during the heat of your initial creative efforts.

Finally you are ready for the first typewritten draft. It will require further review and revision and, following this, you may ask for an evaluation of the scientific contents. Your colleagues or professional associates should provide a fairly impartial hearing. You may not accept their suggestions; in fact, their comments may even be discouraging. In preparing the final copy for possible publication, however, keep their advice in mind. Too often, the editor, who receives your article, is completely discouraged by carelessness in scientific content. When the facts are accurate, he may overlook flaws in presentation. If he should detect faults in both, your pearl is likely to remain forever buried beneath a sea of similar unworthy prose.

References

1. Quince, Peter: How to Write an Article, Perspectives in Biol. & Med. 2(2):221-227 (Winter) 1959.
2. Gunning, R.: The Techniques of Clear Writing, McGraw-Hill, New York, 1952.

▶ Dr. Sowder, P. O. Box 210, Jacksonville 32201.

CONVENTION PRESS

2111 North Liberty St.
Jacksonville, Florida
32206

QUALITY BOOK PRINTING
PUBLICATIONS BROCHURES

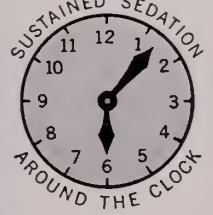
Whatever your first requisites may be, we always endeavor to maintain a standard of quality in keeping with our reputation for fine work — and at the same time provide the service desired. Let Convention Press help solve your printing problems by intelligently assisting on all details.

removes the mental blur

that clouds vision

SOLFOTON®

Each tablet or capsule contains
PHENOBARBITAL.....16 mg.
(Warning: may be habit forming)
BENSULFOID® (See P D R).....65 mg.
Precaution: same as 16 mg. of phenobarbital



Constructive Therapy

A Solfoton tablet or capsule at 6 hour intervals maintains sedation at the threshold of calmness, sustaining a mental climate for purposeful living.

Literature and clinical samples sent upon request.

FEDERAL LAW PROHIBITS DISPENSING WITHOUT PRESCRIPTION

AVAILABLE

Solfoton *(yellow, uncoated tablets "P")*
100s, 500s, 5000s

Solfoton Capsules *(yellow and brown)*
100s, 500s, 1000s

Solfoton S/C *(sugar-coated beige tablets)*
100s, 500s, 4000s

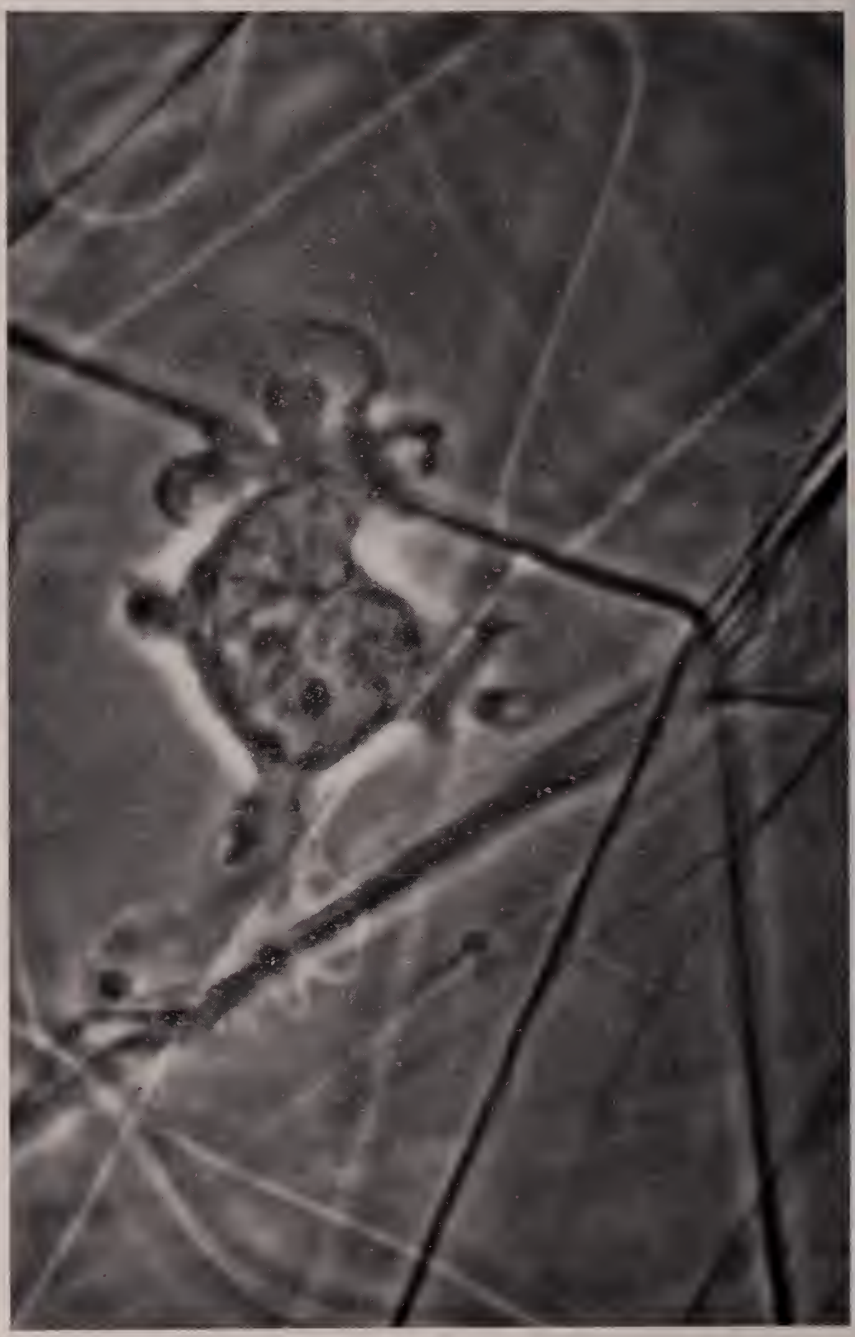
WM. P. POYTHRESS & CO., INC.
RICHMOND, VIRGINIA 23217
Manufacturers of ethical pharmaceuticals since 1856

INFLAMMATION:
A cellular fight for life

A SYNTEX REPORT based on recently developed hypotheses about topical corticosteroids, including the cellular theories of inflammation by Thomas F. Dougherty, Ph.D., University of Utah.

You are looking at a fibroblast fighting for life. This cell – one of the most common found in connective tissue – has literally been poisoned by cytotoxins released from other cells that have ruptured. Soon, if the abnormal activity of this fibroblast does not cease, it, too, will rupture and die – one more casualty in the inflammatory wave of destruction precipitated by injury.

Until a short time ago no one had ever witnessed such a scene at the cellular level. Now, through advanced cinemicrographic techniques, it is possible to view and photograph the inflammatory process as produced experimentally in living animal tissue. This method permits new insight into the mechanism of inflammation and the role of corticosteroids in therapeutic management. Equally important, these techniques shed new light on factors that may make one corticosteroid more effective than another – factors that can be correlated with other chemical, biologic, and clinical parameters.



Visual evidence of how corticosteroids influence the inflammatory reaction

Working with phase-contrast cinemicrography on living animal tissue, Doctors Thomas F. Dougherty and David Berliner of the University of Utah College of Medicine have actually filmed cellular events that occur during the inflammatory reaction. This remarkable study* and additional work by these investigators, as well as by others, have established a new theoretical biologic basis for the antiinflammatory effect of the corticosteroids. (It must be noted that other theories, such as the lysosome or so-called "suicide bag" theory, have been postulated, although it is quite likely that there are more similarities than differences among the various theoretical models.)

The inflammatory wave of destruction

In this investigation an injurious injection of gelatin is used to set off an inflammatory reaction in living mouse tissue. What follows is a wave of destructive cellular activity that comprises the inflammatory response to injury. Mast cells (which contain heparin, serotonin and histamine) take up water, swell and rupture, releasing their contents, which are toxic outside the mast cell wall. These toxins, in turn, cause disintegration of other cells (such as fibroblasts) and the release of additional toxic material. Capillaries, too, take up water and leak unformed blood elements, causing edema. And polymorphonuclears, lymphocytes and perithelial cells invade the inflamed site. As a result of all these changes, the cellular environment reaches a state of turmoil.



Phase-contrast microscopy showing mast cell before injury.



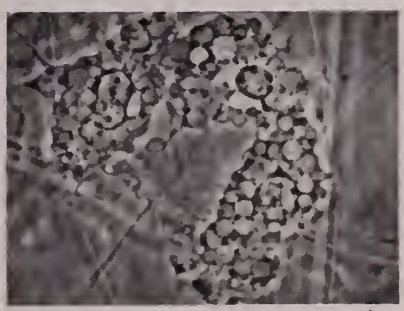
Mast cell (after injury) has broken up and released cytotoxins.

How corticosteroids change the picture

Corticosteroids appear to virtually stop the abnormal cellular activity that constitutes the inflammatory reaction. This permits the body's natural resources to clear up the inflamed area and repair the damaged tissue. This interpretation is supported by the fact that when the injurious gelatin solution is injected simultaneously with a corticosteroid – Synalar (fluocinolone acetonide) – the inflammatory pattern simply does not develop.



Fibroblast in high state of activity, much distorted.



Mast cells showing effects of corticosteroid action: cells are normal in size, shape and activity.



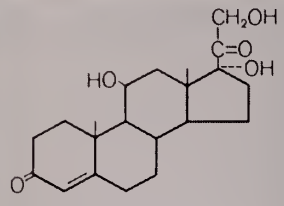
In summarizing his study Doctor Dougherty states: "...we also feel this work may explain why one corticosteroid helps a patient more rapidly and effectively than another. If it does, it is because one corticosteroid is the fastest, most effective inhibitor of the series of inflammatory events at the tissue level."

**A New View of Corticosteroid Action in Inflammatory Dermatoses*, a film based on this study, is now available from your Syntex representative.

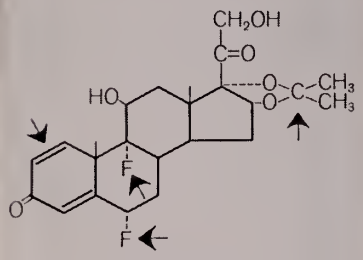
See last page for contraindications, precautions, side effects and dosage

How advances in chemical design have achieved greater steroid potency

The chemical modification of corticosteroid molecules from the advent of hydrocortisone to the development of Synalar (fluocinolone acetonide) is a prime example of how biochemists can "design" to increase therapeutic activity and minimize undesirable side actions. Below, for example, we see the important changes that were made in reference to the hydrocortisone molecule to produce fluocinolone acetonide, one of the most active of all topical corticosteroids. As a result, a 0.01% preparation of Synalar (fluocinolone acetonide) has been reported to do the work of a 1% hydrocortisone product containing 100 times more cortiscosteroid. And it can often do it more effectively.



Hydrocortisone

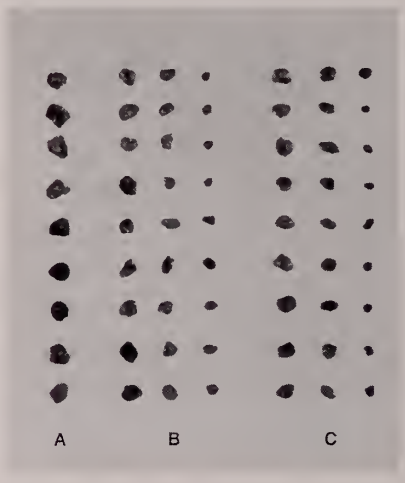


Fluocinolone Acetonide (Synalar)

- *a double bond between carbons 1 and 2*
- *fluorine substitutions at* both *the 6-α, and the 9-α positions*
- *the addition of the acetonide at the 16-α, 17-α positions, thus providing one of the most potent topical corticosteroids available.*

How bioassay tests are used to "predict" therapeutic potential

Biologic assays are another tool used by researchers to help establish the relative activity of corticosteroids. To date no single method of assaying corticosteroid activity has emerged as the ideal "yardstick" for predicting therapeutic potential. Taken together, however, these methods have proved useful. When such tests are run on various corticosteroids, a definite order of corticosteroid activity becomes evident. Compounds with the highest order of activity may be expected to merit clinical trial to establish their high therapeutic potential. When assayed by these methods, fluocinolone acetonide (Synalar) emerges as one of the most active topical corticosteroids, milligram for milligram, available for clinical application today.



THE THYMUS INVOLUTION ASSAY[1-4] is run on adrenalectomized rats. The sizes of the glands are measured, and the degree of involution caused by the steroid is determined as an indication of its potency. In the above photo, the comparative involution of thymus glands achieved with hydrocortisone and Synalar (fluocinolone acetonide) is shown. Untreated controls (A) show normal size. Group B – injected with 1, 2 and 4 mg. of hydrocortisone – show progressively smaller thymuses as does Group C – injected with fluocinolone acetonide – but with only 1/500th the dose of hydrocortisone.



THE ANTIGRANULOMA ASSAY[1-4] also utilizes adrenalectomized rats. Granulomas are induced by subcutaneous implantation of cotton pellets on either side of the thorax. The degree of granuloma inhibition achieved by a steroid reflects its potency. The above photo shows the inhibition of granuloma formation achieved with hydrocortisone and Synalar (fluocinolone acetonide). Untreated controls (A) show large, red granulomas adhering to the pellets. Group B, receiving hydrocortisone and Group C, receiving fluocinolone acetonide, show little, if any, granuloma formation. Fluocinolone acetonide produced the same effect as hydrocortisone with only 1/500th the dose. This assay, as well as the thymus involution assay, measures systemic rather than topical corticosteroid activity. Nevertheless, results by these methods correlate well with other assays and with the milligram potencies of topical steroids in current clinical use.

Worldwide clinical experience confirms the predictable therapeutic potential of Synalar

It is particularly gratifying that the promise of the advanced chemical design and high order of bioassay activity of Synalar (fluocinolone acetonide) has been confirmed by widespread therapeutic application. Indeed, the impressive clinical response rate of Synalar has been documented in no fewer than 232 papers from 22 countries.

Representative Clinical Results with Synalar*

Efficacy Documented in over 4,000 Patients

Condition	Number of Publications	Number of Patients	Significant Improvement†
Contact Dermatitis	27	750	713
Eczematous Dermatitis	21	472	409
Seborrheic Dermatitis	18	442	426
Atopic Dermatitis	24	460	426
Psoriasis	36	1,699	1,510
Neurodermatitis	18	351	324
Total	144	4,174	3,808

*Complete bibliography on request.

†Expressed by the authors as excellent, very good, good, complete remission of inflammation, etc.

PRESCRIBING INFORMATION

For initiation of therapy: Cream 0.025%, 5 and 15 Gm. tubes, 425 Gm. jars; *for emollient effect:* Ointment 0.025%, 15 Gm. tubes; *for maintenance therapy:* Cream 0.01%, 15 and 45 Gm. tubes, 120 Gm. jars; *for intertriginous or hairy sites:* Solution 0.01%, 20 cc. and 60 cc. plastic squeeze bottles; *for infected inflammatory dermatoses:* Neo-Synalar® Cream (0.025% fluocinolone acetonide, neomycin sulfate, equivalent to 0.35% neomycin base), 5 and 15 Gm. tubes.

CONTRAINDICATIONS: Tuberculous, fungal, and most viral lesions of the skin, (including herpes simplex, vaccinia, and varicella). Not for ophthalmic use. Contraindicated in individuals with a history of hypersensitivity to any of the components. PRECAUTIONS: Synalar preparations are virtually nonsensitizing and nonirritating. However, the solution may produce burning or stinging when applied to denuded or fissured areas. In some patients with dry lesions, the solution may increase dryness, scaling or itching. While topical steroids have not been reported to have an adverse effect on pregnancy, the safety of their use on pregnant females has not absolutely been established. Therefore, they should not be used extensively on pregnant patients, in large amounts, or for prolonged periods of time. Prolonged use of any antibiotic may result in overgrowth of nonsusceptible organisms; if this occurs, appropriate therapy should be instituted. When severe local infection or systemic infection exists, the use of systemic antibiotics should be considered, based on susceptibility testing. SIDE EFFECTS: Side effects are not ordinarily encountered with topically applied corticosteroids. As with all drugs, however, a few patients may react unfavorably to Synalar under certain conditions. The neomycin in Neo-Synalar Cream rarely produces allergic reactions.

REFERENCES: 1. Lerner, L. J., Bianchi, A., Turkheimer, A. R., Singer, F. M., and Borman, A.: Anti-inflammatory steroids: potency, duration and modification of activities. Ann NY Acad Sci 116:1071 (Aug. 27) 1964. 2. Idem: Comparison of anti-granuloma, thymolytic and glucocorticoid activities of anti-inflammatory steroids. Proc Soc Exp Biol Med 116:385 (June) 1964. 3. Ringler, A.: Activities of adrenocorticosteroids in experimental animals and man, in Dorfman, R. I.: Methods of hormone research, New York, Academic Press, 1964. vol. III. pp. 234-280. 4. Gubersky, V. R.: To be published.

fluocinolone acetonide — an original steroid from

SYNTEX LABORATORIES INC., PALO ALTO, CALIF.

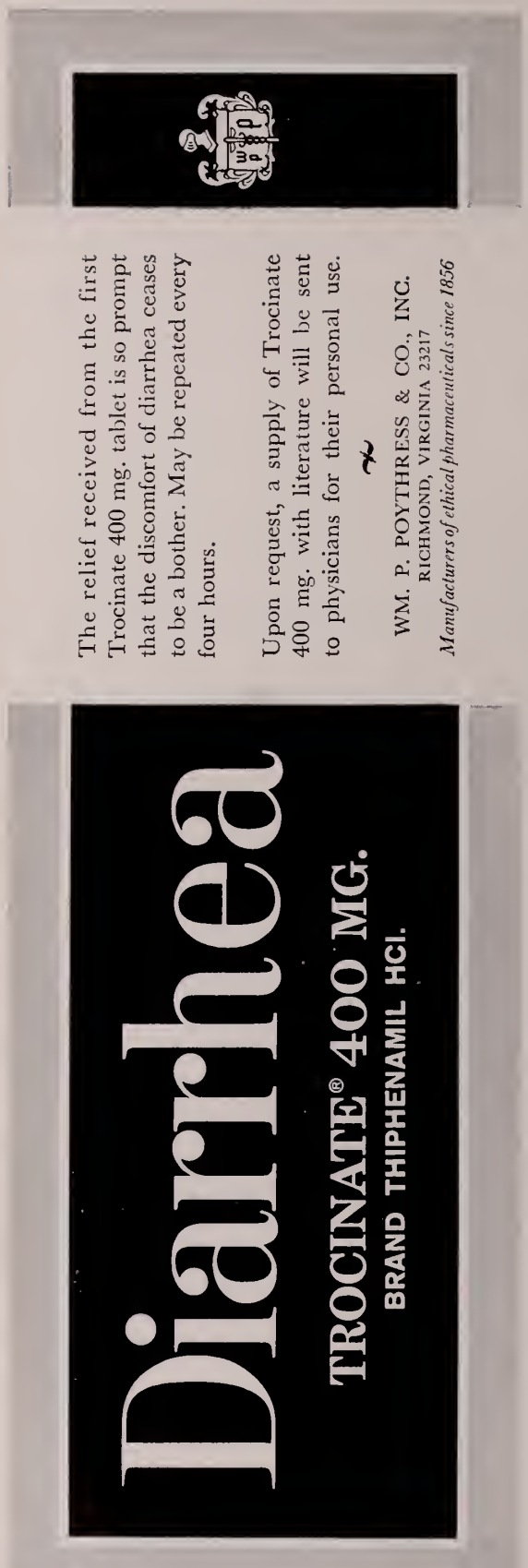
For inflammatory dermatoses... by any measure a topical corticosteroid of choice

Synalar® (fluocinolone acetonide)

Milligram for milligram one of the most active topical corticosteroids available

Rapid and predictable in antiinflammatory and antipruritic activity

Results often comparable to those of systemic corticosteroids with fewer hazards



Meetings

Approved by FMA
Committee on Postgraduate Education

October

5- 7 Neurology-Neurosurgery, J. Hillis Miller Health Center, Gainesville.

21 Duval County Medical Society, Seminar on Shock, Hotel Roosevelt, Jacksonville.

26-28 Today's Hospital Problems: An Interdisciplinary Approach, Tides Hotel and Bath Club, Redington Beach.

27-28 Infectious Diseases Seminar, J. Hillis Miller Health Center, Gainesville.

November

13-17 Selected Topics in Cardiology, Mt. Sinai Hospital of Greater Miami Auditorium, Miami Beach.

16-17 Obstetrics & Gynecology Seminar, J. Hillis Miller Health Center, Gainesville.

December

14-16 Modern Concepts in Surgery and Management of the Lower Extremity Amputee, Americana Hotel, Miami Beach.

January

4- 7 Recent Advances in Local Anesthetics and Regional Anesthesia, Eden Roc Hotel, Miami Beach.

18-20 Pediatric Seminar, J. Hillis Miller Health Center, Gainesville.

25-26 Obstetrics & Gynecology Seminar, J. Hillis Miller Health Center, Gainesville.

26-28 Current Results of Treatment of Gynecological Cancer, Eden Roc Hotel, Miami Beach.

28-Feb. 1—Infectious Disease in Children, Deauville Hotel, Miami Beach.

March

2 Current Medical Concepts, Watson Clinic, Lakeland.

THE DUVALL HOME for RETARDED CHILDREN

A home offering the finest custodial care with a happy home-like environment. We specialize in the care of infants, bed-ridden children and Mongoloids.

For further information write to

MRS. A. H. DUVALL GLENWOOD, FLORIDA



fall 1967

DORSEY

Season

A journal within a journal published quarterly in the interest of better medicine by Dorsey Laboratories, a division of The Wander Company, Lincoln, Nebraska. Address communications to Raymond C. Poore, M.D., Director of Medicine.

this issue: smog, smaze or smust...

Smog, smaze or smust...effects of air pollution on upper respiratory tract

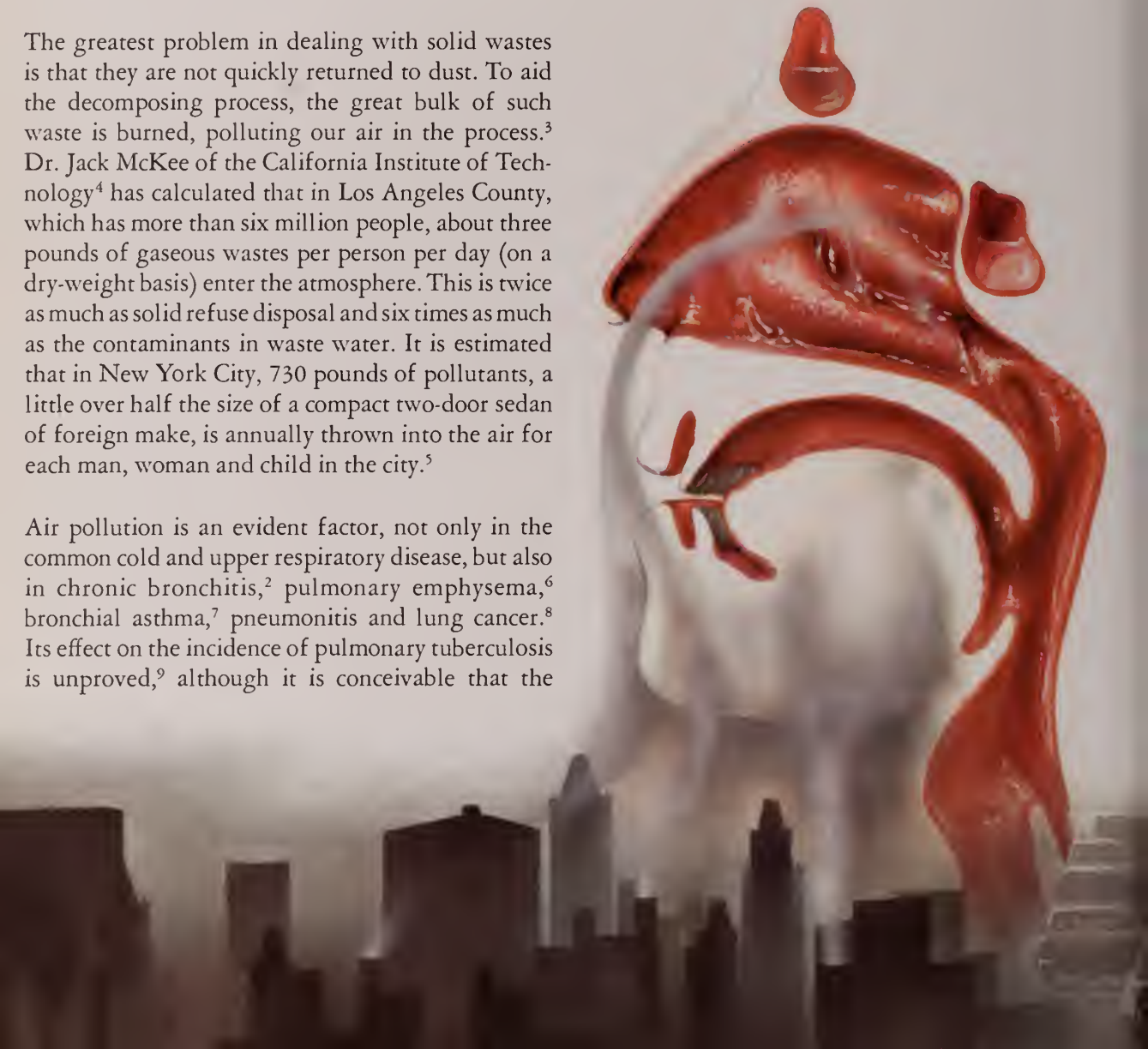
Nathan Flaxman, M.D., Diplomate, American Board of Internal Medicine, Chicago, Illinois

In Los Angeles it is *smog* (smoke and fog). In New York City *smaze* (smoke and haze). In El Paso *smust* (smoke and dust). The original factor was smoke plus such natural phenomena as fog, haze and dust, but air pollution has mushroomed from a smoke problem in our industrial cities into a major economic, esthetic and public health problem that affects practically every American locality and citizen.[1,2] Respiratory disease, of course, is by far the most costly effect of air pollution, for contaminated air can aggravate our illnesses, deplete our strength and shorten our life span.[1]

The greatest problem in dealing with solid wastes is that they are not quickly returned to dust. To aid the decomposing process, the great bulk of such waste is burned, polluting our air in the process.[3] Dr. Jack McKee of the California Institute of Technology[4] has calculated that in Los Angeles County, which has more than six million people, about three pounds of gaseous wastes per person per day (on a dry-weight basis) enter the atmosphere. This is twice as much as solid refuse disposal and six times as much as the contaminants in waste water. It is estimated that in New York City, 730 pounds of pollutants, a little over half the size of a compact two-door sedan of foreign make, is annually thrown into the air for each man, woman and child in the city.[5]

Air pollution is an evident factor, not only in the common cold and upper respiratory disease, but also in chronic bronchitis,[2] pulmonary emphysema,[6] bronchial asthma,[7] pneumonitis and lung cancer.[8] Its effect on the incidence of pulmonary tuberculosis is unproved,[9] although it is conceivable that the presence of various materials polluting the air might do this. A siege of smog in Denver, the "mile high city," in December 1965 was accompanied by respiratory infection that doubled normal absentee rates in schools, factories and city government.[10]

While air pollution is only one factor, it has become important in the causes of most of the afflictions of the respiratory tract. This has been shown not only by the Denver occurrence, but also by detailed study[2] of respiratory illness in a small group of 313 men



from October 1962 to May 1963 when there were 202 episodes involving the upper respiratory tract. The attack rate of illness was related in time to increased concentration of both smoke and sulphur dioxide in the atmosphere of the district in which the men lived.

Other factors often mentioned, include exposure to those who have colds, exposure to extreme changes of temperature, allergy and bacterial infection. However, when low individual resistance due to lack of rest, overwork, fatigue, improper or unbalanced diet, previous illness and emotional stress are included as causes, we enter the realm of somewhat obscure relationships. Much more emphasis can be placed on the role of polluted air.

The symptoms, signs and complications of involvement of the upper respiratory tract, especially the common cold, are the same regardless of the causative factor. Swelling of the lining of the nose, the scratchy dry throat, the discharge from the nose at first watery then thicker, discolored and more tenacious, the eyes tearing, and frequent sneezing are all part of the Number 1 human ailment. Concurrent or residual sinusitis when mucus is trapped there, middle ear involvement due to interference with drainage, laryngitis and bronchitis are complications of the common cold. The primary interference is with a most important function of the nose—the cleansing of foreign matter in the first line of "air defense" to prevent it from entering the breathing tract.

However, the diagnosis and subsequent decision on how to treat the patient so affected rests basically on the relief of symptoms that cause him the misery. The stuffed, runny nose, the clogged ears, and the harsh dry cough—all the symptoms that make common cold sufferers feel miserable and interfere with their sleep—can be alleviated with medications of the oral nasal decongestant/antihistamine combination type. The burning sensation in the throat, soreness of the chest and even chest pain can also be relieved by such medication. Rest in bed if there is fever (but confined to home at least), liberal fluids, uniformly warm surroundings and adequate humidity in the room, are all helpful adjuncts to the medication. Most common cold sufferers recover rapidly and are symptom-free in four to ten days.

Further treatment, altered by the fact that the affliction hangs on for more than the usual duration of the common cold, requires consideration of allergy, which is most frequently the prolonging factor. But air pollution itself may often be the culprit.

(Concluded on following page)

For nature's hazards:
nasal congestion
due to seasonal
allergies and
summer colds



Triaminic® *syrup*

Each teaspoonful (5 ml.) contains:

Phenylpropanolamine hydrochloride	12.5 mg.
Pheniramine maleate	6.25 mg.
Pyrilamine maleate	6.25 mg.

For nasal congestion regardless of cause, you can bring quick, lasting comfort to your little patients with Triaminic Syrup. You may occasionally encounter these side effects: drowsiness, blurred vision, cardiac palpitations, flushing, dizziness, nervousness or gastrointestinal upsets. Precautions: the possibility of drowsiness should be considered by patients engaged in mechanical operations requiring alertness. Use with caution in patients with hypertension, heart disease, diabetes, or thyrotoxicosis.

(Advertisement)



At the Third National Conference on Air Pollution held recently, it was emphasized that this subject had received more attention in the past four years than in all previous history. Spicer,[11] an active participant at this conference, reiterated that it behooves the practicing physician to be aware of trends in respiratory disease and to accept a major role in community action relating to air pollution and respiratory health. By taking a positive stand physicians have been instrumental in the development of anti-pollution legislation. An outstanding example is Los Angeles where major steps have been taken by abolishing coal burning, and even banishing oil burning, seven months a year. Natural gas must be used instead and it must be used by industry when available. Backyard incinerators have been abolished in favor of landfill disposal, and building incineration ended except for a few expensive smokeless furnaces.[10] Concerted action can be taken against particular industrial nuisances. One company that disregarded complaints discovered its error when thousands of its credit cards were returned by irate customers who decided to patronize competing companies.[12]

Summary. Respiratory disease is the most important and most costly effect of air pollution, whether termed smog, smaze, or smust. Air pollution is an economic, esthetic and public health problem that affects practically every American locality and citizen. New sources of air pollution are invisible and odorless, but the harmful gases and liquid droplets are there. Triggered by sunlight, some of these undergo mid-air chemical changes and the results are even more irritating to the upper respiratory tract. The symptoms, signs and complications, especially of the upper respiratory tract, can be readily aborted by modern medication but may be unduly prolonged by polluted air. In steps taken to prevent this, the practicing physician can take a major role.

References 1. Anderson, R. J. Air Pollution, Respiratory Disease and the NTA, W. Virg. M. J., 60:332, 1964. 2. Angel, J. H., Fletcher, C. M., Hill, I. D., and Tinker, C. M. Respiratory Illness in Factory and Office Workers, Brit. J. Dis. Chest, 59:66, 1965. 3. Waste Disposal Problems Grow, Current Municipal Problems, 8:218, 1966. 4. McKee, J. quoted by Hills, G. U.S. War at Home-Fight Against Smog, Chicago Tribune, Sept. 26, 1966. 5. NYC Task Force Revives Concern on Air Pollution, Med. Trib. 7:23 (Sept. 17-18) 1966. 6. Flaxman, N. Pulmonary Emphysema, Med. Trial Tech. Quart. 1960 Annual, p. 221. 7. Heimann, H. Air Pollution and Respiratory Disease, Ann. Allergy 21:396, 1963. 8. Flaxman, N. Pneumonitis and Lung Cancer, Med. Trial Tech. Quart. 1965 Annual, p. 185. 9. Flaxman, N. Pulmonary Tuberculosis, Occupation and Trauma, Med. Trial Tech. Quart. 1959 Annual, p. 237. 10. Hill, G. U.S. War at Home-Fight Against Smog, Chicago Tribune, Sept. 26, 1966. 11. Spicer, W. S., Jr. Relation of Air Pollution to Disease, Arch. Environ. Health, 9:600, 1964. 12. Henderson, C. F. What You Can Do To Combat Air Pollution, Parents' Mag. 41:76, 1966.

How can he be a sport with a runny nose?



For summer allergies, summer colds, or nasal congestion due to almost any cause, you prescribe quick r-e-l-i-e-f with Triaminic. It's ideal for summer allergies:

1. Acts in 15-30 minutes due to decongestant.
2. Follows up with balanced dual antihistamines.
3. Up to 24-hour 'round the clock relief when dosed one tablet at morning, midafternoon and evening.

Summer time is sport time and who can be a sport with a runny nose?

provide patient comfort

Triaminic® relieves summer allergies

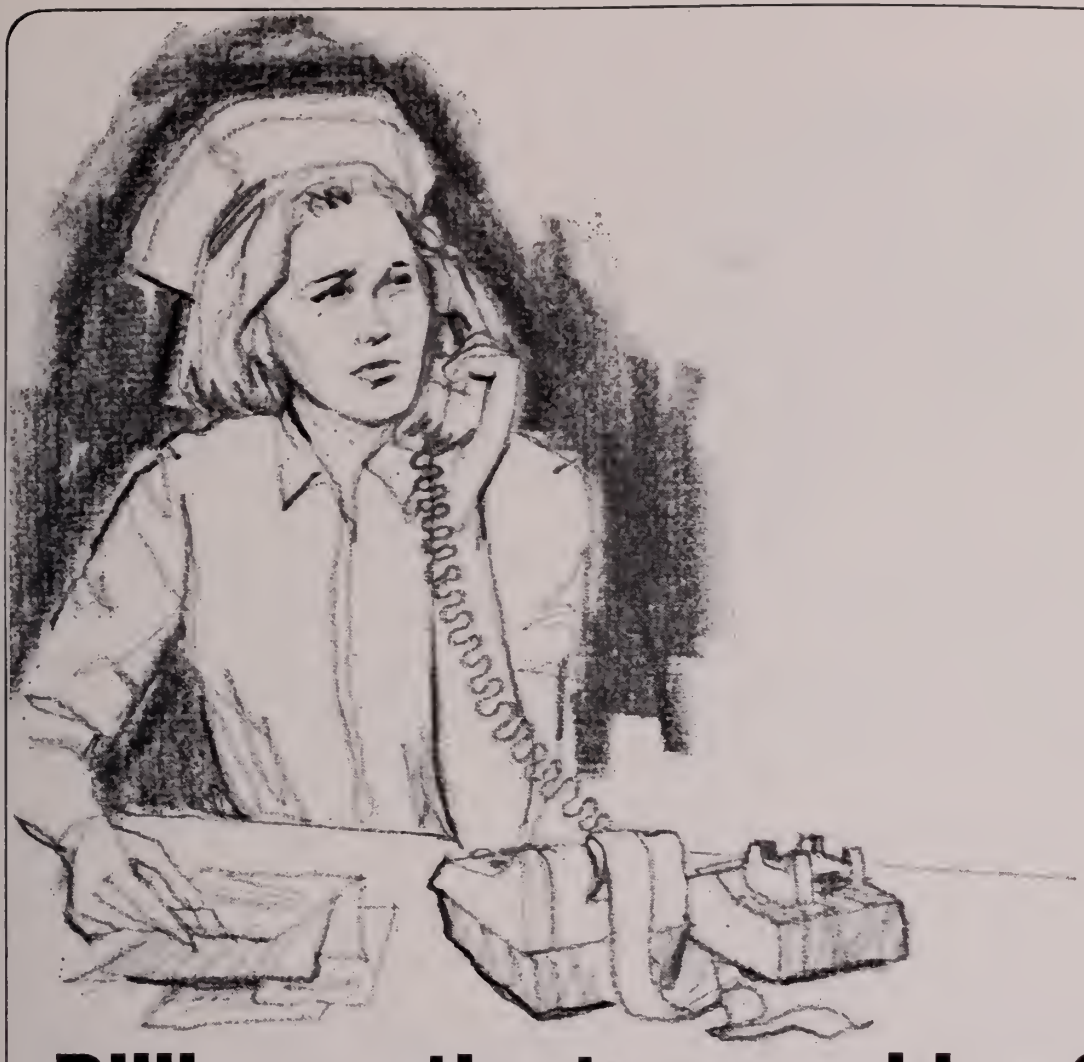
Each timed-release tablet contains:

Phenylpropanolamine hydrochloride	50 mg.
Pheniramine maleate	25 mg.
Pyrilamine maleate	25 mg.

Side effects: Occasional drowsiness, blurred vision, cardiac palpitation, flushing, dizziness, nervousness or gastrointestinal upsets.

Precautions: The patient should be advised not to drive a car or operate dangerous machinery if drowsiness occurs. Use with caution in patients with hypertension, heart disease, diabetes or thyrotoxicosis.

(Advertisement)



Billing patients a problem?

We specialize in medical billing . . . It's our *only* business. Professional Billing Corporation's ethical, courteous, efficient Accounts Receivable System increases your cash receipts to the maximum and reduces office "girl time."

PBC can serve you in your own area and offer you unexcelled accuracy in computerized billing with a professional, yet personal, touch.

PBC's system requires minimal time of a doctor's office staff. PBC provides your patients with an understandable, clearly itemized statement that reduces unnecessary phone calls to your office.

To eliminate the greater portion of billing problems in your office, contact PBC now while you are thinking about it . . . There is no obligation.

Professional Billing Corporation
1311 East Morehead Street
Charlotte, N. C. 28204

Gentlemen: I am interested in improving the billing & accounts control system in my Practice. Please provide details of the PBC Program designed to increase cash receipts and save "girl time." There is no obligation.

Name

Street Address

City State Zip

PBC
Professional
Billing
Corporation
1311 East Morehead Street
Charlotte, N. C. 28204
Phone 704/375-4541



Special Article

A Rubeolad Classic

THOMAS COLLINS, M.D.

Once upon a time there lived a Virus in the Kingdom. He was a very happy Virus, allowed to come and go as he pleased. Being completely independent, he soon lost sight of what was considered proper behavior and began pestering all the children in the Kingdom. Because he was primarily a pest, and because he bothered all children, his actions were tolerated by one and all as a "part of growing up."

One day a man came to the Kingdom who claimed he could grow other members of the family of the Virus in his laboratory. He did, but these brothers, sisters and cousins proved to be more troublesome to the children than the Virus. The King decided to charge his subjects with the responsibility of training these relatives not to be troublesome to children. After many years of difficult, costly work, the training was successful.

Soon it became possible to grow these relatives in the laboratory so that they would protect children rather than disturb them. Then, the Kingdom was rendered relatively free of many severe diseases that previously had brought suffering to many children. There remained, however, the ubiquitous Virus who, as a matter of routine, continued to pester each child as he grew up.

"Perhaps," reasoned the King, "we may be able to train this Virus so that he will protect children rather than pester them." Many of his subjects questioned the wisdom in this possibility. "Why bother?" asked Ens. F. E. Litus, one of the King's hottest brains, "he is only a nuisance."

The King pondered a long time over this remark. When he could not answer it satisfactorily, he decided to ask the children.

"Please don't change the Virus," said one young lad. "When it was my turn to be pestered, I had to stay home from school for two weeks. It was kind of like a vacation, but I felt too tired to get out of bed. My mother had to stay home and take care of me."

A little girl told the King that as long as everyone else had to be bothered by the Virus, she did not mind. "I only wish my ears did not hurt so badly," she added, wincing.

In his wisdom, the King recognized that perhaps the children were not in a position to determine what was best for them. He invited his subjects to appear at the palace on a certain day and give their opinions. When the time came, however, there were only a few, numbering about two for each 1,000 children. Quickly the King

learned that they were the parents whose children had been pestered by the Virus to the extent that they were very hot and slept all the time. Most of them did wake up after many days, normal again, but one in each 10 was never the same, and one out of four never woke up.

The King cried: "We have misjudged this Virus. He is evil and his actions must be tolerated no longer. Is there some chance that he can be trained to protect rather than harm children?"

The advisors to the King gave their answer. "Yes," they shouted, "he can be trained. He already is; we have been working day and night. He is here, ready to beg forgiveness, ready to take his place as a protector. No child need be pestered by him ever again."

"So be it," the King ruled, "let it be known that all children shall receive him."

And so, the Trained Virus and all the children lived happily ever after, one protecting and the other providing a home for the protector.

▸ Dr. Collins, Florida State Board of Health, P. O. Box 210, Jacksonville 32201.

YOUR Patronage Has Made Our Growth Possible

Medical Supply Company of Jacksonville



Home Office

JACKSONVILLE
4539 Beach Blvd.
Telephone FL 9-2191

ORLANDO
1511 Sligh Blvd.
Telephone GA 5-3537



Recognize this?
Chloresium® Ointment
—it's recognized for effectiveness in healing ulcers, soothing burns, deodorizing wounds. Use this coupon for samples. Rystan

Chloresium Ointment
Brand of water-soluble chlorophyll derivatives

RYSTAN COMPANY (F)
117 Mt. Vernon Ave.
Mt. Vernon, New York
Please send me literature and free samples of CHLORESIUM OINTMENT

Dr. _____

Street _____

City _____ State _____ Zip _____



Perhaps there have been times when you wanted to prescribe erythromycin and triple sulfas for little patients. Now you can—with a choice of two new fine-tasting pediatric forms.

New–Two Pediatric Forms of Erythromycin and Triple Sulfas





ERYTHROCIN®-SULFAS Chewable (Erythromycin ethyl succinate-trisulfapyrimidines chewable tablet)

In clinical trials[1,2], this orange-flavored tablet was given to 55 patients, aged four months to 18 years.

Diagnoses (multiple in some cases) represented a cross section of bacterial infections commonly seen in pediatric office practice.

Therapy was given from three to 12 days, with an average of six days.

Of the 55 patients, 30 were reported cured within 72 hours, while 22 showed partial recovery within the same time, and subsequent clinical cure.

A clinical cure rate of 94.5%

ERYTHROCIN®-SULFAS Granules (Erythromycin ethyl succinate-trisulfapyrimidines granules for oral suspension)

87 patients were treated[1,2]—all children, ages four months to 15 years.

The diagnoses were multiple in some cases and were chiefly bacterial infections of the respiratory tract.

Dosage was maintained from three to 10 days; average treatment was five days. All of the ill children accepted the orange-flavored suspension favorably.

53 were clinically cured within 72 hours, while 32 showed partial relief within the same time, and subsequent clinical cure.

701358

A clinical cure rate of 97.7%

1. Case Reports on File, Dept. Clin. Development, Abbott Laboratories.
2. Polley, R.F.L., Use of Erythromycin-Sulfas in Office Practice, Western Med., 7:177, July, 1966.

ABBOTT

Brief Summary on next page

ERYTHROCIN®-SULFAS
Brief Summary

Contraindications: Known sensitivity to erythromycin or sulfonamides. Because of the possibility of kernicterus with sulfonamides, do not use in pregnancy at term, premature or newborn infants.

Warnings: As with other forms of sulfonamide therapy, carefully evaluate patients with liver or kidney damage, urinary obstruction, or blood dyscrasia. Deaths have been reported from hypersensitivity reactions and blood dyscrasias following use of sulfonamides. Perform blood counts and liver and kidney function tests if used repeatedly at close intervals or for long periods.

Precautions, Side Effects: Occasionally mild abdominal discomfort, nausea or vomiting may occur with erythromycin, generally controlled by reduction of dosage. Mild allergic reactions (such as urticaria and other skin rashes) may occur. Serious allergic reactions have been extremely infrequent. Use sulfonamides with caution in patients with a history of allergy. Assure adequate fluid intake to prevent crystalluria and institute alkali therapy if indicated. If overgrowth of nonsusceptible organisms occurs, withdraw the drug and institute appropriate treatment. If a patient should show signs of hypersensitivity, appropriate countermeasures (e.g. epinephrine, steriods, etc.) should be administered and the drug withdrawn.

Adverse Reactions: Sulfonamide therapy may be associated with headache, nausea, vomiting, urticaria, diarrhea, hepatitis, pancreatitis, blood dyscrasias, neuropathy, drug fever, skin rash, injection of the conjunctiva and sclera, petechiae, purpura, hematuria and crystalluria.

Side effects due to erythromycin are infrequent, but occasional abdominal discomfort, nausea, or vomiting, urticaria and other skin rashes may occur.

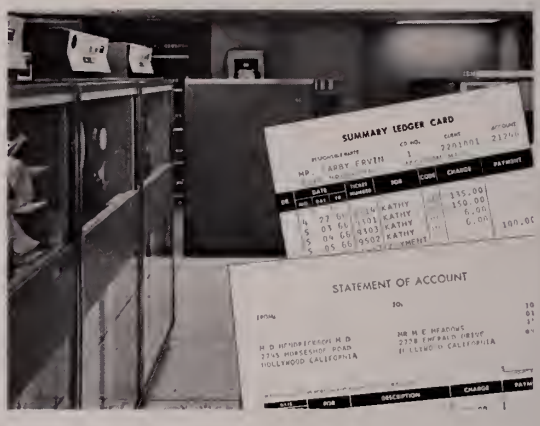
Supplied: The Granules for Oral Suspension come in bottles of 60 ml. and 150 ml. The Chewable tablets are in bottles of 50. Each 5-ml. teaspoonful of reconstituted Granules or each Chewable tablet provides erythromycin ethyl succinate equivalent to 125 mg. of erythromycin activity and 167 mg. of each of sulfadiazine, sulfamerazine and sulfamethazine.

ABBOTT

701358

ASSOCIATED MANAGEMENT INC.
FIRST FEDERAL BUILDING
8340 N.E. 2ND AVENUE
MIAMI, FLORIDA 33138

Accounts receivable management system
designed specifically for doctors



This system offers doctors the advantage of computer techniques for accounts receivable management with no investment in equipment. All that's required from the doctor is a daily report voucher on each patient. From this, AMS furnishes a whole series of regular reports and analyses plus the preparation of each patient's monthly statement. The cost is usually far less than doing your own bookkeeping.

We are part of a National Concern serving Doctors for over 6 years.

☐ Please send me your Accounts Receivable Management Brochure.

☐ Please have one of your consultants call me for an appointment.

Name

Address

City Phone



DUAL PROBLEM IN PEPTIC ULCER

Relief of hyperacidity is still a primary goal in the treatment of peptic ulcer. And antacids are the most widely used means of achieving this relief. But antacids alone cannot influence the distention and bloating which so often add to ulcer distress.

THIS IS WHY MYLANTA® PROVIDES:

the two most widely used antacids—magnesium and aluminum hydroxides—to help secure rapid acid neutralization with little chance of laxation or constipation;

PLUS

the defoaming action of simethicone—to help relieve the painful gas symptoms which often accompany peptic ulcer.

Mylanta®

antacid therapy plus an added benefit

nonfatiguing flavor/smooth pleasant texture; both assure patient cooperation during long-term therapy.

Stuart Division of / ATLAS CHEMICAL INDUSTRIES, INC. / Pasadena, Calif.

There are 59,700* undetected diabetics in Florida

Most of these are probably among patients over 40; the overweight; relatives of diabetics, and mothers of large babies. By the time polyphagia, polyuria, polydipsia, pruritus or other overt symptoms of diabetes appear, damage may have been done that could have been minimized. DEXTROSTIX® gives you a reliable blood-glucose estimate in 60 seconds.

Why Wait?



*Based on Statistical Report, U.S. Dept. Commerce, ed. 86, and Fisher, G. F., and Vavra, H. M.: Pub. Health Rep. 80:961 (Nov.) 1965.

Note: DEXTROSTIX is not meant to replace the more precise analytical laboratory procedures such as needed in glucose tolerance testing.

AMES COMPANY, Division Miles Laboratories, Inc., Elkhart, Indiana 46514 428R67

Ames



"Man's best friend" in wintertime diarrheas

In winter "flu" and viral gastroenteritis, Donnagel (4 oz. size!) can bring aid and comfort to sufferers from both diarrhea and its discomforts because it contains kaolin and pectin *plus* belladonna alkaloids (as in Donnatal®). Donnagel treats the whole diarrhea problem. Available on your prescription or recommendation.

For acute, non-specific diarrheas
Donnagel® -PG (Donnagel with paregoric equivalent).
Donnagel formula plus powdered opium, USP, 24.0 mg. (equivalent to paregoric 6 ml.) (warning: may be habit forming). Alcohol, 5%.

All the antidiarrheal benefits of paregoric without the unpleasant taste. Real banana flavor makes it acceptable, even to children.
See product literature before prescribing.
A. H. Robins Company
Richmond, Va. 23220

A·H·ROBINS

CLEAR THE TRACT! ROBITUSSIN



THERE'S A FORMULATION FOR EVERY COUGHING NEED

All the Robitussins contain glyceryl guaiacolate, the outstanding expectorant agent that greatly increases the output of lower respiratory tract fluid. Increased RTF volume exerts a demulcent effect on the tracheo-bronchial mucosa, promotes ciliary action, and makes thick, inspissated mucus less viscid and easier to raise.

For coughs of colds and "flu"
ROBITUSSIN®
Each 5 cc. contains:
Glyceryl guaiacolate 100 mg.
Alcohol, 3.5%

For unproductive allergic coughs
ROBITUSSIN® A-C
Each 5 cc. contains:
Glyceryl guaiacolate 100 mg.
Pheniramine maleate 7.5 mg.
Codeine phosphate 10.0 mg.
(warning: may be habit forming)
Alcohol, 3.5%

Non-narcotic for 6-8 hour cough control
ROBITUSSIN®-DM
Each 5 cc. contains:
Glyceryl guaiacolate 100 mg.
Dextromethorphan hydrobromide . 15.0 mg.
Alcohol, 1.4%

New! Clears sinuses and nasal stuffiness as it relieves cough
ROBITUSSIN®-PE
Each 5 cc. contains:
Glyceryl guaiacolate 100 mg.
Phenylephrine hydrochloride . . . 10.0 mg.
Alcohol, 1.4%

	ROBITUSSIN	ROBITUSSIN A-C	ROBITUSSIN-DM	ROBITUSSIN-PE
EXPECTORANT	●	●	●	●
DEMULCENT	●	●	●	●
COUGH SUPPRESSANT		●	●	
ANTIHISTAMINE		●		
LONG-ACTING (6-8 HOURS)			●	
NASAL, SINUS DECONGESTANT				●

PHOTO BY VICTOR HAND

A. H. Robins Company, Richmond, Va. 23220

A·H·ROBINS

Don't let monilia cut broad-spectrum therapy short...

start with Tetrex-F®

tetracycline phosphate complex-nystatin

Use of broad-spectrum antibiotics can cause fungal overgrowth in the alimentary tract... and give rise to symptoms so troublesome that therapy must be prematurely stopped. Tetrex-F (tetracycline phosphate complex-nystatin) helps you circumvent this problem.

The nystatin can prevent overgrowth of monilia; the phosphate complex delivers tetracycline to the blood rapidly. Side effects are infrequent.

High-Risk Patients

Tetrex-F (tetracycline phosphate complex-nystatin) is especially useful in patients most susceptible to fungal overgrowth during tetracycline therapy: (1) the elderly or debilitated, (2) young children, (3) the diabetic, (4) those on long-term tetracycline therapy, (5) those on steroid therapy, (6) those who have had moniliasis before, and (7) pregnant patients with a history of monilial vaginitis.

When you start with economical Tetrex-F (tetracycline phosphate complex-nystatin), you can complete the full course of broad-spectrum therapy with less chance of losing control elsewhere. A good start for a healthy finish.

PRESCRIBING INFORMATION. For complete information consult Official Package Circular. *Indications:* Infections of respiratory, gastrointestinal and genitourinary tracts and skin and soft tissues due to tetracycline-sensitive organisms, in patients with increased susceptibility to monilial infections. *Contraindications:* The drug is contraindicated in patients hypersensitive to its components. *Warnings:* Photodynamic reactions have been produced by tetracyclines. Natural and artificial sunlight should be avoided during therapy. Stop treatment if skin discomfort occurs. With renal impairment, systemic accumulation and hepatotoxicity may occur. In this situation, lower doses should be used. Tooth staining and enamel hypoplasia may be induced during tooth development (last trimester of pregnancy, neonatal period and childhood). *Precautions:* Bacterial superinfections may occur. Infants may develop increased intracranial pressure with bulging fontanels. In gonorrheal therapy, serologic tests for syphilis should be conducted initially and monthly for 3 months. *Adverse Reactions:* Glossitis, stomatitis, nausea, diarrhea, flatulence, proctitis, vaginitis, dermatitis, and allergic reactions may occur. *Usual Adult Dosage:* 1 capsule q.i.d. Continue for 10 days in Beta-hemolytic streptococcal infections. Administer one hour before or two hours after meals. *Supplied:* Capsules, bottles of 16 and 100. Each capsule contains tetracycline phosphate complex equivalent to 250 mg. tetracycline HCl activity and 250,000 units of nystatin. For Oral Suspension, 125 mg. tetracycline and 125,000 u. nystatin/5 ml., 60 ml. bottles.

BRISTOL

BRISTOL LABORATORIES
Division of Bristol-Myers Company
Syracuse, New York 13201



Special Article

'By the Numbers' Receipted Bill System

ROBERT E. RABORN, M.D., ALLYN F. JUDD,, M.D. and DONALD E. BEBOUT, M.D.

A simple, accurate and time-saving method of providing the patient with a receipted bill to facilitate third party reimbursement has been used successfully in our office for the past year.

The patient is identified by his Medicare or other third party claim number. The medical condition is described through use of the last four digits of diagnoses numbers as listed in Current Medical Terminology, Third Edition, published by the American Medical Association. Procedures are identified by utilizing four-digit numbers drawn from Current Procedural Terminology, First Edition, also published by the AMA. Both books may be obtained from the AMA for $4 and $2 respectively.

The charge for services rendered is set by the individual physician. Payment is acknowledged by an appropriate "Paid" rubber stamp and initialed by an office assistant or bookkeeper. The billing form can be tailored to meet individual requirements of any type of practice. A carbon or pressure-sensitive paper produces a copy for office records. We presently use an original and one carbon; however, different colored multiple copies also may be used.

CMT numbers are the same as both the 1962 Florida Medical Association relative value study and the 1965 Florida Society of Internal Medicine study. Diagnoses are listed alphabetically in part one of CMT. The disease for which the patient has received treatment is identified by the last four CMT digits.

The use of numbers avoids phone calls, fear and confusion of the patient and allows multiple diagnoses to be listed in a small space. For example, the patient may be treated for several interrelated diseases such as diabetes (1923), arteriosclerotic heart disease (4491) and coronary occlusion (1921), all of which can and should be listed on the bill for accuracy and completion.

A short-cut diagnoses finder may be prepared by arranging alphabetically in a telephone desk index the CMT diagnoses numbers most frequently used. For example, to find the diabetes mellitus CMT number, press the index open to "D" and the diagnosis and corresponding number are quickly found (fig. 1.).

Computer data on Blue Shield and other insurance carriers have been gathered for several

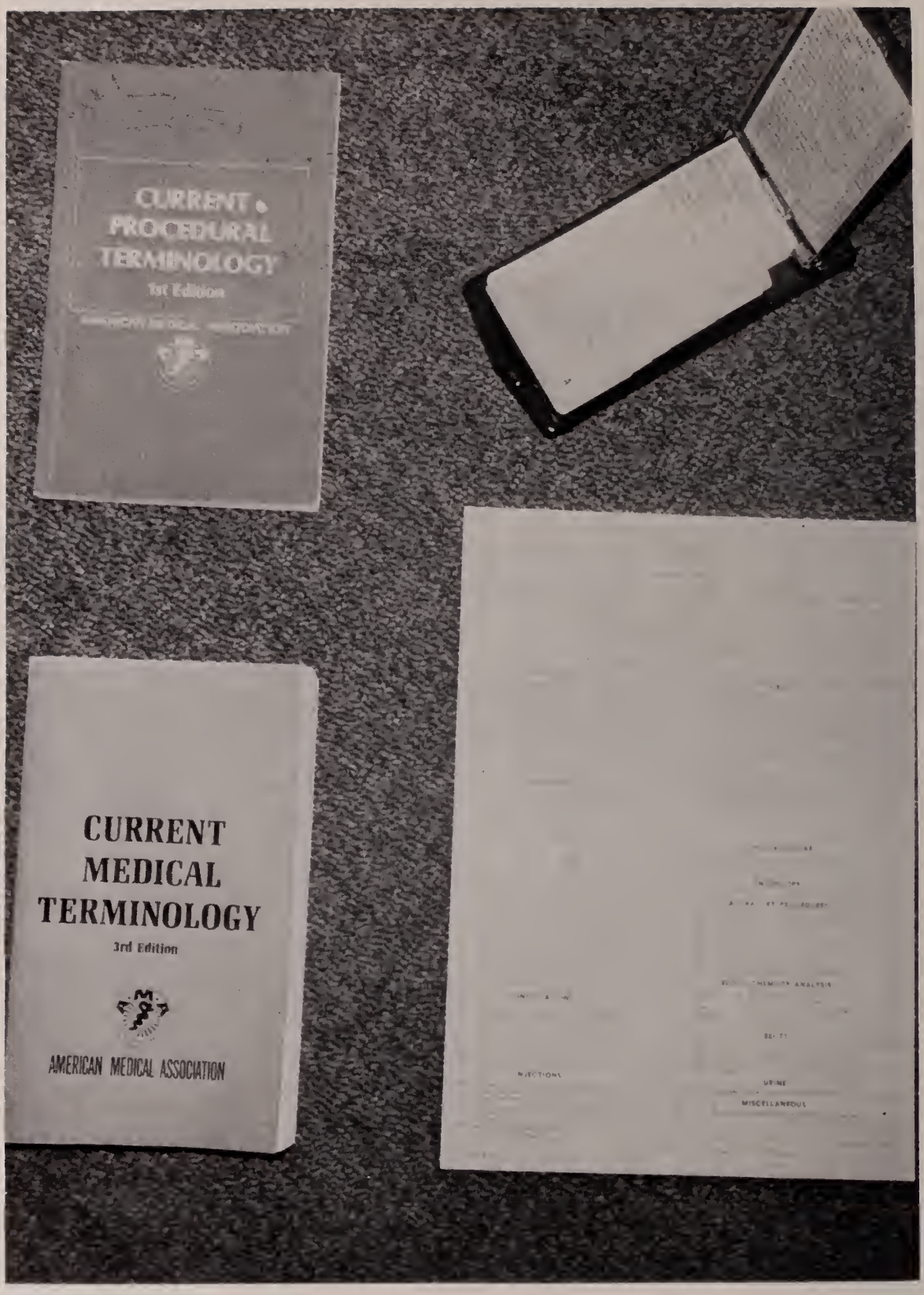

CURRENT
PROCEDURAL
TERMINOLOGY
1st Edition
CURRENT
MEDICAL
TERMINOLOGY
3rd Edition
AMERICAN MEDICAL ASSOCIATION

Fig. 1

Patient's Name _____

Address _____

City _____ Telephone _____

Claim No. _____

Current Medical (1)____ (4)____ (7)____
Terminology Nos. (2)____ (5)____ (8)____
AMA, Vol. 3 (3)____ (6)____ (9)____

Signature _____

OFFICE VISITS

9001 Initial office visit, routine, new patient or new illness, history and examination
9002 Initial office visit, complete diagnostic history and physical examination
9005 Follow-up office visit necessitating professional care over and above routine office visit
9006 Follow-up office visit, prolonged, over and above 9005
9007 Follow-up office visit necessitating complete re-examination and re-evaluation of patient as a whole.
9008 Same illness or new illness

HOME VISITS

9012 Initial home visit, complete diagnostic history and physical examination
9015 Follow-up home visit necessitating professional care over and above routine visit
9073 Night calls requested between 5 p.m. & 7 a.m.

HOSPITAL VISITS

9020 Initial hospital visit, routine, history and physical examination, including initiation of diagnostic and treatment programs and preparation of hospital records
9021 Initial hospital visit, complete diagnostic history and physical examination, known patient or chronic condition, including initiation of diagnostic and treatment programs and preparation of hospital records
9022 Initial hospital visit, complete diagnostic history and physical examination, new patient or major acute illness, including initiation of diagnostic and treatment programs and preparation of hospital records
9024 Follow-up hospital visit necessitating care over and above routine visit
9025 Follow-up hospital visit necessitating complete re-examination and re-evaluation of patient as a whole, same illness
9071 Prolonged detention with patient in critical condition

CONSULTATIONS

9026 Consultation requiring limited examination of a given system but not requiring a complete diagnostic history and examination, home, office, or hospital
9027 Consultation requiring more extensive examination, but not requiring complete diagnostic history and examination, home, office, or hospital
9028 Consultation requiring complete, diagnostic history and examination, office, home, or hospital

INJECTIONS

1046 Arthrocentesis: puncture for aspiration of joint effusion (not traumatic), or injection of medication, initial or subsequent
1413 Needle puncture of bursa, with or without aspiration and with or without irrigation, initial and subsequent
1517 Injection of medication, tendon sheath
Injection, Other, (Med. included)

Flu Vaccine

X-RAY

7101 PA and lateral Chest
7100 Single PA
7110 Ribs, unilateral
7111 Bilateral
7204 Cervical, A-P and lateral, Spine
7206 Cervical, including oblique and special flexion studies
7207 Thoracic, A-P and lateral
7210 Lumbo-sacral, A-P and lateral
7211 Complete lumbo-sacral study, including oblique studies
7217 Pelvis, A-P
7247 Shoulder, complete study
7248 One projection
7350 Abdomen, single A-P
7351 Complete studies
7364 Cholecystography, oral dye

CARDIOVASCULAR

9101 Electrocardiogram, with interpretation and report
9104 Exercise test with interpretation and report
9420 Electroconversion of cardiac arrhythmia

ENDOSCOPY

3310 Proctosigmoidoscopy, diagnostic, initial

LABORATORY PROCEDURES

8620 Blood, red cell count
8622 Hemoglobin determination, photoelectric
8624 White cell count
8626 Differential count
8628 Complete count
8681 Hematocrit
8720 Sedimentation rate
8708 Prothrombin time, each
8704 Platelet count
8917 Cytologic study (Papanicolaou type), screening

BLOOD CHEMISTRY ANALYSIS

Glucose	Bei (Thyroxin)	Protein Total
Bun	Cholesterol	Albumin
Sgot	Alk. Phos.	Globulin by Diff.
Creatinine	Bilirubin Total	A/G Ratio
	Uric Acid	

BEI T3

8726 Sugar
8652 Cholesterol
8611 Bilirubin (Van den Bergh, direct and indirect)
8744 Urea
8746 Uric acid

URINE

8934 Complete routine (chemical and microscopic)

MISCELLANEOUS

9074 Services at unusual hours for patient's convenience

Credit Courtesy (Subtract)
TOTAL

Fig. 2

years and this "by the numbers" system provides a simple method of utilizing those data. In our experience, the bookkeeper instructs the patient to sign his name to the third party form and attach the "by the numbers" receipt before mailing to the intermediary. Charges will vary for procedures performed; enough descriptions of the services appear in CMT, FMA or FSIM relative value studies to adjust and justify charges to meet the current range of values and usual and customary fees. Part two of CMT lists the diagnoses numbers in numerical series, making conversion easy for Blue Shield and other Medicare intermediaries.

The cost for the forms is small after the initial expense of formulation. A printer may be helpful with trial proofs in adapting the form to fit a particular practice. The time spent by the physician checking the diagnosis is negligible once the medical assistant has completed the form and attached it to the patient's record. For patients who have been hospitalized, a copy of the discharge summary is attached to supplement the information when prolonged detention, intensive care or complications occur. Forms of this type please both the patient and the office assistant and simplify the work of the physician. Copies of our form (Fig. 2) and coding of diagnoses are included; they are not copyrighted, and those interested are invited to make use of any part or all of this method.

▶ Dr. Raborn, P. O. Box 1120, Delray Beach 33444.

Code of Diagnoses

A

Adams Stokes syndrome	4501
Adrenal glucocoricoids Tax	1443
Alcoholism, acute	1489
Alcoholism, chronic	3400
Anemia, aplastic	3322
Anemia, def. of folic acid	1034
Anemia, def. of iron	3310
Anemia, hemolytic, Acg. Auto	2052
Anemia, pernicious	3678
Anemia, posthemorr., acute	3637
Anemia, sideroblastic refract.	4242
Anemia, simple chronic	1981
Aneurysm, aorta, abdominal	3134
Aneurysm, aorta, thoracic	4606
Aneurysm, artery	2070
Aneurysm, lower extremity	4054
Aneurysm, berry	4767
Angina pectoris	4750
Aortic valve insufficiency	4934
Aphasia, receptive	4258
Aphasia, expressive	2802
Appendicitis, acute	4700
Arteriosclerosis, cerebral	2318
Arteriosclerosis	2134
Arteriosclerosis, medial	2970
Arthritis, rheumatoid	2873
Arthritis, traumatic, primary	4853
Asthma, bronchial	4622
Atelectasis, abropt. collpse	2319
Atherosclerosis	1797
Atherosclerosis, obliterans	1892
Atrial fibrillation	4702
Atrial flutter	4736
AV block 2°	1074
AV block 3°	2431
Atrophy, macular	3038

B

Bladder, ca transit	2017
Bladder, contracture	1382
Bladder, neurogenic, atonic	4799
Bladder, neurogenic, reflex	4860
Bladder, papilloma	2380
Brain syndrome, acute	1945
Brain syndrome, chronic	3081
Brain concussion	3463
Brain hemorrhage	2495
Breast Ca	3020
Breast cystic disease	2218
Bronchitis, acute	2389
Bronchitis, chronic	1541
Bronchopneumonia	3979
BBBL	3061
BBBR	3046
Bursitis	1305
Bursitis, radiohumeral	3086
Bursitis, subacromial	3368

C

Capillaries, fragility	3412
Carbon dioxide narcosis	3029
Carbuncle	4652
Carotid artery, int. occlus.	4793
Cataract, cortical	3009
Cataract, nuclear	3377
Cataract, senile	1734
Cataract, traumatic	1263
Cellulitis	1735
Cephalgia, histamine	4399
Cerebrovascular insuff.	1171
Cerumen, impacted	1365
Cholecystitis, acute	3496
Cholecystitis, chronic	4554
Choledocholithiasis	4695
Cholelithiasis	3773
Chorea, senile	4043
Coin lesion	1889
Colitis, ulcerative	4522
Colon, adenomatous polyp	3259
Colon, Ca	4998
Colon, diverticulosis	2911
Colon, irritable	1390
Conjunctivitis, catarrhal, acute	2943
Cor pulmonale	4332
Coronary insuff. synd.	3142
Coumarin toxicity	1825
Cushing syndrome incl iatro	4807
Cystitis, acute	3855
Cystocele	3572

D

Deafness conduction (middle ear dis)	2441
Delirium tremens	1481
Dementia, senile	1951
Dermatitis	4298
Dermatitis, medicamentosa	2213
Dermatitis, seborrheic	4255
Diabetes mellitus	1923
Diarrhea, chronic	2377
Digitalis toxicity	2591
Diverticulitis	1431
Drugs, toxicity	2591
Dumping syndrome	4300
Duodenitis	4271
Dupuytren contracture	4286

E

Ecchymosis	4326
Embolism, artery	1883
Embolism, art. pulmonary	2587
Embolism, cerebral	2496
Emphysema, pulmonary	4259
Epilepsy, grand mal	2006
Epilepsy, petit mal	4960
Epilepsy, post-traumatic	2084
Epithelioma, basal cell	2071
Esophagitis, peptic chronic	3671
Esophagus, varix	2520
Exophthalmos	2446

F

Feces, impacted	4488
Fibrosis, pulmonary	3840
Fibrositis	2346
Food allergy	2931
Foot fracture, phalanges	4582
Fracture	3746

G

Gallbladder, hydrops	2828
Gangrene	3041
Gangrene, diabetic	3032
Gastritis, acute	3122
Gastroenteritis, non-bact.	4169
Gastrointestinal hemorrhage	3945
Glaucoma, open angle	2462
Glaucoma, narrow angle	1064
Glomerulonephritis, chronic	1859
Glomerulosclerosis	1070
Goiter, simple, non-endemic	1257
Goiter, substernal	3949

Goiter, toxic, nodular 1639
Gout 3302
Graves disease 1574

H

Hallux valgus 3702
Hamman-Rich syndrome 4207
Hay fever 3906
Heart, AS disease 4491
Heart block S-A 2331
Heart failure, congestive 3390
Heart failure, left side, acute 2763
Heart, hypertensive disease 2797
Heart, hypertrophy 2254
Heart, nodal rhythm 4337
Hemiplegia 2860
Hemopneumothorax 1210
Hemorrhoids 4710
Hepatitis, cholestatic 3407
Hepatitis, infectious 1578
Hernia, diaphragmatic 2756
Hernia, epigastric 4059
Hernia, femoral 1473
Hernia, incisional 1384
Hernia, inguinal, indirect 2290
Hernia, umbilical 1855
Herpes simplex 2231
Herpes zoster 3656
Hodgkin disease 4754
Hordeolum 2824
Hydrarthrosis, intermit. 4565
Hydrocele 1128
Hydronephrosis 4026
Hydrothorax 2168
Hypercholesterolemia ess. 2221
Hyperinsulinism 2646
Hypertension, essent. 3580
Hypertension, malig. 3581
Hypertension, portal 1849
Hypertension, pulmon. 2945
Hypertension, second. 3686
Hypertension, renal 3641
Hyperthyroidism 2007
Hypoglycemia 2095
Hypoglycemia, reactive 2687
Hypoprothrombinemia 4457
Hypotension, orthostat. 1298
Hypothyroidism 1608
Hysteria 2013

I

Ichthyosis 2193
Ileus, adynamic 4417
Infectious mono. 4575
Influenza 4726
Insect bites 4703
Intervertebral disc, rupture 4601
Intestine, obstruction 2477

J

Jaundice, obstructive 1367

K

Keloid 3593
Keratosis, seborrheic 4003
Kidney, calculus 4025
Kidney, failure, acute 2229
Kidney, failure, chronic 3028
Kidney, infarct. 1670
Kidney, papillary necrosis 2711
Kidney, polycystic disease 4167
Kidney, renal cell Ca 2029
Kidney, tuberculosis 3294
Kidney, tubular nec., acute 4091
Kunkel syndrome 2402
Kyphosis 4281

L

Labyrinth, hemorrhage 3063
HVD sudden complete hearing loss-tinnitus unilateral
Labyrinthitis, acute diffuse sup. 4873
Sudden temp. hearing nystagmus to good side
Labyrinthitis, latent 4921
compl. perm. deafness
Laryngeal n. unilat. paralysis 1091
Laryngitis, acute 4444
Laryngitis, chronic 1353
Larynx, edema, acute 1621
Lens absence 2230
Leukemia, acute 1922
Leukemia, chronic 3351
Leukemoid reactions 2657
Leukoplakia 3506
Lichen planus 4401
Light eruption, polymorph 1989
Lip, lower, carcinoma 2703
Lip, upper, carcinoma 3714
Lipoma 2731
Liver, cirrhosis, Laennec 1090
Liver, cirrhosis, postnecrot. 3568
Liver, cir. pri. biliary 4320
Liver, cirrhosis with CPC 2606
Liver, fatty 1320
Liver, CPC 1093
Liver, ptosis 2145
Liver, yel. atrophy, acute 2672
Loeffler syndrome 3927
Lung abscess 4076
Lung, Ca. aveolar cell 4620
Lung Ca, bronchogenic 1647
Lung congestion 3185
Lung edema 4190
Lung hemorrhage 3002
Lung infarction 1292
Lung mid. lobe syndrome 4598
Lymphadenopathy 2272
Lymphangitis 3536
Lymphedema, congenital 3558
Lymphedema, secondary 3060
(surg. inf.)
Lymphosarcoma 1917

M

Measles (rubeola) 3813
Melanoma, juvenile 1323
Meningitis, aseptic 4635
Meningitis, suppurative 2310
Meningoencephalitis 2020
Meniscus, ruptured 3810
Menopause syndrome 3207
Mesenteric vasc. insuf. synd. 3271
Metaplasia, myeloid, agnogen 1771
Migraine, syndrome 4599
Mitral valve insuff. 4545
Mitral valve stenosis 2174
Multiple sclerosis 2312
Mumps 2780
Myasthenia gravis 3187
Myelofibrosis 3918
Myeloma, multiple 1319
Myocardial infarction 1921
Myopia 4473
Myxedema 2323

N

Nabothian cyst, cervix 4245
Nails, dystrophy 1079
Nephritis, lupus 1635
Nephrotosis 2194
Nephrosclerosis, arteriolar 1038
Nephrosis, toxic 1488
Nephrotic syndrome 1659
Neuralgia, glossopharyngeal 2974
Neuralgia, sphenopalatine 2335
Neuralgia, trigeminal 4113
Neuritis 2307
Neuritis 3735
Neuritis, sciatic 3137
Neurocirculatory asthenia 2567
Neurodermatitis, local 1167
Neuropathy, diabetic 4479
Neuropathy, ischemic, leg. 3353
Nevus, intradermal 4744
Nevus, junctional 4247
Nevus, spider 4268
Nose, polyp 4270
Nystagmus 4270

O

Obesity 1569
Optic atrophy, primary 3615
Optic atrophy, second. 3471
Orchitis, mumps 1648
Orchitis, non-specific 3601
Osteitis deformans (Paget) 3143
Osteoarthritis 3169
Osteoarthropathy, hypertrophic sec. 3798
Osteoma 1823
Osteomalacia 2512
Osteoporosis 1652
Otitis externa, acute 4644
Otitis media, chronic 3753
Otosclerosis 4303

P

Pacemaker, wandering 3935
Palsy, cerebral 1165
Palsy, glossopharyngeal 4305
Palsy, pseudobulbar 1252
Pancreas, Ca. body & tail 2830
Pancreas, Ca, head 2383
Pancreas, cyst, false 2471
Pancreas, cyst, true 1978
Pancreatitis, chronic 4256
Pancreatitis, hemorr. acute 4307
Pancytopenia 2480
Paralysis, extrinsic, eye m. 3895
Paralysis, facial 4291
Paranoia 3467
Paranoid state 4591
Parkinsonian syndrome 4071
Parkinsonism 4309
Paronychia 4210
Pectus excavatum 1767
Penicillin toxicity 3398
Peptic ulcer syndrome 1374
Peptic ulcer hemorrhage 1332
Pericarditis, acute 4756
Pericarditis, benign 2549
Pericarditis, constrictive 3540
Pericardium calcific 4891
Peritoneum adhesions 4439
Peritonitis 4415
Personality antisocial 2188
Pes cavus 3930
Pharyngitis, acute 2618
Pickwickian syndrome 1907
Pityriasis rosea 4172
Pleura, calcification 2754
Pleurisy fibrinous 4153
Pleurodynia, epidemic 1408
Pneumonia, aspiration 2525
Pneumonia, lobar 4946
Pneumonia, prim. atyp. 1903
Pneumothorax, spont. 4944
Polycythemia, sec. 1226
Polythemia vera 4122
Post myocardial inf. synd. 4361
Post commissurotomy synd. 2329
Prostate, BRH 3667
Prostate, calculus 3812

Prostate, Ca 2137
Prostatitis, acute 4758
Prostatitis, chronic 3022
Pruritis 4228
Pruritis ani 3571
Psoriasis 2369
Pyelonephritis, acute 4209
Pyelonephritis, chronic 1007
Psychotic react. involut. 3265
Pterygium 3824
Pulmonary valve stenosis 4130
Purpura, allergic 1946
Purpura, hemorr. 4236
Purpura, thrombocyt sympt. 1293

R

Radiation injury 1287
Raynaud disease 2964
Raynaud phenomenon 1037
Rectocele 3838
Rectum, Ca 3836
Rectum, polyp 2692
Rectum, prolapse 3277
Respiration Cheyne-Stokes 3318
Restless legs syndrome 1498
Retina detachment 1807
Retina hemorrhage 4835
Retinitis pigmentation 2527
Retinopathy, hypertensive 1748
Rheumatic fever, acute 1593
Rheumatic heart disease, active 2563
Rheumatic valvulitis 2187
Rhinitis, acute 3459
Rhinitis, allergic 4922
Rhinitis, chronic hypertr. 1230
Rhinophyma 2424
Rib fracture 4714
Rosacea 2267
Rotor syndrome 3876
Rubella 4089

S

Salicylate toxicity 1180
Salivary duct calculus 1219
Salpingitis, acute 1609
Sarcoidosis 2636
Sarcoma, retic cell 4879
Schizophrenic reaction 2799
Scleritis 1905
Scleroderma circumscrbd 1185
Scleroderma, diffuse 1661
Sclerosis, amyothroph. lat 4749
Scoliosis, congenital 3209
Scoliosis, idiopathic 1613
Scoliosis, paralytic 3299
Sebaceous gland cyst 3414
Septicemia 1404
Serum sickness 4129
Shock, electric 1317
Shoulder-hand syndrome 1506
Sialandenitis 1676
Simmonds disease 3830
Sinusitis 2554
Skene glands, adenitis 1004
Skin Ca, basal cell 1345
Skin Ca, epidermoid 2892
Skin melanocarcinoma 3323
Skin, senile atrophy 2755
Skull fracture 3533
Spina bifida occulta 2643
Spinal cord, subact. com 4232
Spine, whiplsh inj. cerv. 4397
Spleen, infarct 3723
Splenic flex, syndrome 2297
Splenomegaly, congest. 3901
Spondylolisthesis 3879
Spondylosis, cervical 2788
Spondylosis, lumbar 1402
Sprain 2584
Sprue, non-tropical 4956
Sprue, tropical 2676
Sting, insect 3283
Sting, fish (Man'oWar) 1123
Stomach, Ca 1470
Stomatitis aphthous 1906
Strabismus comitant 1983
Stabismus, non-comitant 3860
Strain 4581
Subarachnoid hemorrhage 2785

T

Tachycardia, PAT 1540
Tachycardia, nodal parox. 2201
Tachycardia, sinus 3348
Tachycardia, ventric. parox 1493
Talipes, valgus varus 4745
Telangiectasia 3458
Telangiectasia, hered, hem 1911
Temporo-mand. jt. disloc. 3039
Tendinitis 1726
Tenosynovitis, fingers 2772
Tenovaginitis, wrist 2252
Testes, ectopic 1030
Testes, prim. seminal fail. 1745
Tetany 3048
Thromboangiitis obliterans 3534
Thrombocytopenia (ITP) 1870
Thrombophlebitis 1132
" -recurrent, idiopthc 4959
Thrombosis, aorta abdom. 2332
Thrombosis, cerebral 1080
Thyroglossal duct cyst 4478
Thyroiditis, chr. fibrous 2132
Thyroiditis, chr. lymphocy. 4870
Thyroiditis, granulomat. 1532
Tietze syndrome 1172
Tinea corporis 2602
Tinea cruris 2912
Tinea pedis 3007
Tinea versicolor 1898
Toenail, ingrown, infect. 2158
Tongue, black, hairy 4350
Tongue, hemangioma 1728
Tonsil, abscess 4935
Tonsillitis, acute 1224
Torticollis 4783
Transfusion react. hem. 4800
Transfusion, react. infect. 4824
Tremor, hereditary 1702
Trichomonas vaginalis 4890
Tricuspid valve insuf. 3594
Tricuspid valve stenosis 2876
Tuberculosis, primary 1863
Tuberculosis, pulmonary 1012
Tympanic memb. perf. 3856
Tympanic memb. sclerosis 2406

U

Ulcer, anastomotic 3998
Ulcer, decubitus 3549
Ulcer, varicose 3161
Urachus, cyst 4739
Uremia 2365
Ureter, calculus 3512
Urethra, caruncle 1896
Urine retention 1442
Urticaria, allergic 3274
Uterine cervix, Ca 1184
Uterine cervix erosion 4830
Uterus leiomyoma 3465
Uterus prolapse 1427

V

Vagina moniliasis 4597
Vaginitis, atrophic 2064
Varicose veins 2652
Ventricular fibrillation 3058
Viremia 2367
Vitiligo 1168
Von Willebrand disease 4405

W

Wart 3759
Wart, plantar 2259
Wolff-Parkinson-White syndrome 4398
Wound infection 3316

Anderson Surgical Supply Co.

Established 1916

Distributors of Known Brands of Proven Quality

TELEPHONE 229-8504
Morgan at Platt, P. O. Box 1228
TAMPA, FLORIDA 33601

TELEPHONE 376-8253
236 S.W. 4th Ave.
GAINESVILLE, FLORIDA

TELEPHONE 896-3107
556 9th St., South
ST. PETERSBURG, FLORIDA

TELEPHONE CHerry 1-9589
1818 N. Orange Ave.
ORLANDO, FLORIDA

A Building Block approach to treating hypertension

With these three therapeutic building blocks you can create a once-a-day regimen to fit almost any degree of hypertension. See the following pages for details . . .



Consider starting your hypertensives on this basic thiazide

ABBOTT

A single daily dose of Enduron provides sodium excretion around the clock

Enduron is a true 24-hour single-dose thiazide. Its sodium excretion is not squeezed into an abrupt peak during the first several hours. It is well-sustained in a plateau-like effect—with little reduction for the first 12 hours, and decline thereafter only gradual.

Potassium loss, by contrast, is low. It reaches an early minor peak, then subsides rapidly. Moreover, since dosage is but once a day, there is but one daily peak of potassium loss. As with all thiazides, however, dietary potassium supplementation should also be considered, especially in long or intensive therapy.

Use Enduron as an ideal starting therapy in mild hypertension. Use it too, as a basic therapeutic building block with which other agents can be joined, for managing your more resistant hypertensives.

Once a day, every day

ENDURON®
METHYCLOTHIAZIDE



DAILY DOSAGE RANGE	Minimum	Usual	Intermediate	Maximum
	2.5 mg. tablet	5 mg. tablet	7.5 mg.	10 mg.

See Brief Summary on final page of advertisement.

To build added response, shift to Enduronyl

The deserpidine component adds enhanced antihypertensive activity

The rauwolfia component of Enduronyl is deserpidine (Harmonyl®), a purified crystalline alkaloid supplied only by Abbott. It augments Enduron with its own antihypertensive and tranquilizing action.

Thus the combined clinical effect of these two therapeutic building blocks in Enduronyl is greater than can ordinarily be achieved with either alone.

To add flexibility, Enduronyl comes in two strengths: regular and Forte. Both provide 5 mg. of Enduron. The variation is where most helpful: in the deserpidine. The tablets are scored, and give a surprisingly wide and economical choice of once-a-day doses (see below).

Choose Enduronyl for your patients in the broad range of mild to moderate hypertension. Patient acceptance is excellent!



Once a day, every day

ENDURONYL®

METHYCLOTHIAZIDE 5 MG. WITH DESERPIDINE 0.25 MG.

ENDURONYL FORTE

METHYCLOTHIAZIDE 5 MG. WITH DESERPIDINE 0.5 MG.

	Minimum	Usual	Intermediate	Maximum
DAILY DOSAGE RANGE	2.5 mg. methyclothiazide 0.125 mg. deserpidine	5 mg. methyclothiazide 0.25 mg. deserpidine	7.5 mg. methyclothiazide 0.375 mg. deserpidine	10 mg. methyclothiazide 0.5 mg. deserpidine
DAILY DOSAGE RANGE	2.5 mg. methyclothiazide 0.25 mg. deserpidine	5 mg. methyclothiazide 0.5 mg. deserpidine	7.5 mg. methyclothiazide 0.75 mg. deserpidine	10 mg. methyclothiazide 1 mg. deserpidine

See Brief Summary on final page of advertisement.

707075-R

Eutonyl affords a different kind of basic therapy for moderate to severe cases

ABBOTT

Effect tied to reduced peripheral vascular resistance; no central depressant action

Eutonyl is a unique nonhydrazine agent. It is reported to act by reducing peripheral vascular resistance.[1,2]

In clinical trials, significant reductions in mean blood pressure were seen in 84% of patients studied—all were moderate to severe cases. Eutonyl lowers diastolic in proportion to systolic, and in about half of the cases studied, reductions in the sitting and recumbent positions were nearly as great as in the standing position.

Most important: There is no central depressant action. In fact, some patients reported an *increased* sense of well being.

Here, then, is a highly effective *basic treatment* for moderate to severe cases—and one that will not hamper your patient with lethargy or drowsiness while on treatment.

Once a day, every day

EUTONYL®
PARGYLINE HYDROCHLORIDE



DAILY DOSAGE RANGE	Minimum	Usual starting	Intermediate	Maximum
	10 mg. tablet	25 mg. tablet	50 mg. tablet or as needed	200 mg.

1. Brest, A. N., et al., Cardiac and Renal Hemodynamic Response to Pargyline, Ann. N. Y. Acad. Sci., 107-1016, 1963.
2. Winsor, T., Pargyline Hydrochloride, Hypertension, Urinary Tryptamine, and Vascular Reflexes, Geriatrics, 19:598, Aug., 1964.

See Brief Summary on final page of advertisement.

Eutron adds thiazide for enhanced therapy with milder side effects

ABBOTT

Only a 7/4 mm. span between standing and recumbent pressures in clinical trials—reduced chance of orthostatic hypotension

The combining of Eutonyl and Enduron in Eutron permits a significantly greater antihypertensive effect than with either agent used alone. This in turn may allow therapeutic success with lesser dosage—and correspondingly milder side effects.

A significant finding in clinical trials was the drug's action in lowering blood pressure to *nearly equal levels in all body positions*. Total average spread between standing and recumbent readings (after treatment) was only 7/4 mm. Hg.

Thus, in your moderate to severe cases, Eutron affords a usually smooth course of therapy, often with reduced likelihood of orthostatic effects. (The usual precautions against rising suddenly, of course, will always apply.) And, because of the thiazide component, Eutron may be used in the presence of congestive heart failure.



Once a day, every day

EUTRON™

PARGYLINE HYDROCHLORIDE 25 MG.
WITH METHYCLOTHIAZIDE 5 MG.

	Minimum	Usual starting	Intermediate	Maximum
DAILY DOSAGE RANGE	 12.5 mg. pargyline hydrochloride and 2.5 mg. methyclothiazide	 25 mg. pargyline hydrochloride and 5 mg. methyclothiazide	 37.5 mg. pargyline hydrochloride and 7.5 mg. methyclothiazide	 50 mg. pargyline hydrochloride and 10 mg. methyclothiazide

See Brief Summary on final page of advertisement.

TM—Trademark

707075-R

ENDURON® | ENDURONYL®

METHYCLOTHIAZIDE

Each tablet contains
Methyclothiazide 5 mg. with
Deserpidine 0.25 mg. or 0.5 mg.

Indications: Enduron is used to control edema and mild to moderate hypertension; also used with other drugs for hypertension. Enduronyl is used in mild to moderately severe hypertension; when used with Enduronyl, more potent agents can be given at reduced dosage to minimize undesirable side effects.

Contraindications: Neither Enduron nor Enduronyl should be used in severe renal disease (except nephrosis) or shutdown; in severe hepatic disease or impending hepatic coma; in patients sensitive to thiazides. Hepatic coma has been reported as a result of hypokalemia in patients receiving thiazides.

Enduronyl is contraindicated in patients with severe mental depression and suicidal tendencies, active peptic ulcer, or ulcerative colitis.

Warnings: Consider possible sensitivity reactions in patients with a history of allergy or asthma. If added potassium intake is indicated, dietary supplementation is recommended. Enteric-coated potassium tablets should be reserved for cautious use only when adequate dietary supplementation is not practical because those tablets may induce serious or fatal small bowel lesions consisting of stenosis with or without ulceration. These small bowel lesions have caused obstruction, hemorrhage and perforation frequently requiring surgery. Medication should be discontinued immediately if abdominal pain, distension, nausea, vomiting or GI bleeding occurs.

Precautions: Use thiazides with caution in severe renal dysfunction, impaired hepatic function, or progressive liver disease. In surgical patients, thiazides may reduce the response to vasopressors and increase the response to tubocurarine. Use thiazides with caution in pregnancy (bone marrow depression, thrombocytopenia, or altered carbohydrate metabolism have been reported in certain newborn infants). Also reported have been: blood dyscrasias including thrombocytopenia with purpura, agranulocytosis and aplastic anemia; elevations of BUN, serum uric acid, or blood sugar. Symptomatic gout may be induced. Antihypertensive response may be enhanced following sympathectomy.

Use Enduronyl with caution in patients with a history of peptic ulcer, as rauwolfias may increase gastric secretion. Discontinue at the first sign of mental depression. Rauwolfia alkaloids may increase hypotensive effects of surgery or anesthesia, and should be discontinued two weeks prior. They also lower the convulsive threshold and shorten seizure latency. In epilepsy, dosage adjustment of anticonvulsant medication may be necessary. Alcohol, barbiturates, or narcotics may potentiate action of deserpidine.

Adverse Reactions: During intensive or prolonged therapy, guard against hypochloremic alkalosis and hypokalemia (especially the latter if patient is on digitalis). All patients should be observed for signs of hyponatremia ("low-salt" syndrome). Reported thiazide reactions include: anorexia, nausea, vomiting, diarrhea, headache, skin rash, dizziness, paresthesia, weakness, photosensitivity, jaundice, and pancreatitis.

Reported rauwolfia reactions include: nasal stuffiness, nausea, weight gain, diarrhea, aggravation of peptic ulcer, epistaxis, skin eruption, and reduction of libido and potency. Excessive drowsiness, fatigue, weakness, and nightmares may signal early signs of mental depression.

EUTONYL® | EUTRON™

PARGYLINE HYDROCHLORIDE

Each tablet contains
Pargyline Hydrochloride 25 mg.
with Methyclothiazide 5 mg.

Indications: For treatment of patients with moderate to severe hypertension, especially those with severe diastolic hypertension. Not recommended for patients with mild or labile hypertension amenable to therapy with sedatives and/or thiazide diuretics alone. It is desirable to establish the dosage of Eutron by administering component drugs separately.

Contraindications: Pheochromocytoma, advanced renal disease, increasing renal dysfunction, paranoid schizophrenia and hyperthyroidism. Hepatic coma has been reported as consequence of hypokalemia with thiazide therapy. Until further experience is gained not recommended for patients with malignant hypertension, children under 12, or pregnant patients.

Concomitant use of the following is contraindicated: other monoamine oxidase inhibitors; parenteral forms of reserpine or guanethidine; sympathomimetic drugs; foods high in tyramine such as cheese; imipramine and amitriptyline, or similar antidepressants; methyldopa. 2 week interval should separate therapy and use of these agents.

Methyclothiazide is contraindicated in patients with known sensitivity to thiazides.

Warnings: Pargyline hydrochloride is a monoamine oxidase inhibitor. Warn patients against eating cheese, and using alcohol, proprietary drugs or other medication without the knowledge of the physician. When indicated, alcohol, narcotics (meperidine should be avoided), antihistamines, barbiturates, chloral hydrate, and other hypnotics, sedatives, tranquilizers, or caffeine, may be used cautiously in reduced dosage. In emergency surgery ¼ to ⅕ the usual dose of narcotics, analgesics, and other premedications should be used avoiding parenteral administration where possible. Carefully adjust dose of anesthetics to response of patient. Withdraw pargyline two weeks before elective surgery.

Warn patients about the possibility of postural hypotension. Those with angina or coronary artery disease should not increase physical activity with an improvement in well being. Pargyline may lower blood sugar.

Avoid use of enteric-coated potassium tablets, as these may induce serious or fatal small-bowel lesions consisting of stenosis with or without ulceration. These small-bowel lesions have caused obstruction, hemorrhage and perforation frequently requiring surgery. Medication should be discontinued immediately if abdominal pain, distension, nausea, vomiting or GI bleeding occurs. These products contain no added potassium salts and if added potassium intake is desired, dietary supplementation is recommended. Coated potassium tablets should be reserved for cautious use when adequate dietary supplementation is impractical. In patients with a history of allergy or asthma the possibility of sensitivity reactions should be considered.

Precautions: Measure blood pressure while patient is standing to determine antihypertensive effect. Use with caution in hyperactive or hyperexcitable persons. Such persons may show increased restlessness and agitation. Withdraw drug during acute febrile illness. Watch patients with impaired renal function for increasing drug effects or elevation of BUN and other evidence of progressive renal failure; withdraw drug if such alterations persist and progress. Use with caution in patients with liver disease. As with all new drugs, complete blood counts, urinalyses, and liver function tests should be performed periodically. With prolonged therapy, examine patients for change in color perception, visual fields and fundi. Also reported have been: blood dyscrasias including thrombocytopenia with purpura, agranulocytosis and aplastic anemia; elevations of BUN, serum uric acid, or blood sugar. Symptomatic gout may be induced. In surgical patients thiazides may reduce response to vasopressors and increase response to tubocurarine.

Adverse Reactions: Pargyline may be associated with orthostatic hypotension. Mild constipation, slight edema, dry mouth, sweating, increased appetite, arthralgia, nausea and vomiting, headache, insomnia, difficulty in micturition, nightmares, impotence, delayed ejaculation, rash, and purpura have been encountered with pargyline. Hyperexcitability, increased neuromuscular activity (muscle twitching) and other extrapyramidal symptoms have been reported in a few patients with reduced cardiac reserve.

During intensive or prolonged therapy, guard against hypochloremic alkalosis and hypokalemia (especially the latter if patient is on digitalis). Observe all patients for signs of hyponatremia ("low salt" syndrome).

Reported thiazide reactions also include anorexia, nausea, vomiting, diarrhea, headache, dizziness, paresthesia, weakness, skin rash, photosensitivity, jaundice, and pancreatitis. Nocturia has been observed with the combination.

709075R

ABBOTT

TM-Trademark.



"All Registered Nurses are Alike"

It stands to reason. They all go through the same training; they all have to pass the same tests; they all have to measure up to the same standards. Therefore, all registered nurses are alike.

That's nonsense, of course. But it's no more nonsensical than what some people say about aspirin. Namely: since all aspirin is at least supposed to come up to certain required standards, then all aspirin tablets must be alike.

Bayer's standards are far more demanding. In fact, there are at least *nine specific differences* involving purity, potency and speed of tablet disintegration. These Bayer® standards result in significant product benefits including gentleness to the stomach, and product stability that enables Bayer tablets to *stay* strong and gentle until they are taken.

So next time you hear someone say that all aspirin tablets are alike, you can say, with confidence, that it just isn't so.

You might also say that all registered nurses aren't alike, either.



when bursitis hits a 280-lb. tackle, hit back with Butazolidin alka

Indications: Osteoarthritis, rheumatoid arthritis, rheumatoid spondylitis, psoriatic arthritis, acute gout, painful shoulder (peritendinitis, capsulitis, bursitis and acute arthritis of that joint), acute superficial thrombophlebitis.

Contraindications: Edema; danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. The drug should not be given when the patient is senile or when other potent drugs are given concurrently. Large doses of Butazolidin alka are contraindicated in glaucoma.

Warning: If coumarin-type anticoagulants are given simultaneously, watch for excessive increase in prothrombin time. Instances of severe bleeding have occurred. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea, sulfonamide-type agents and insulin. Carefully observe patients receiving such therapy. Use with great caution in the first trimester of pregnancy.

Precautions: Before prescribing, carefully select patients, avoi those responsive to routine measures as well as contraindicated tients. Obtain a detailed history and a complete physical and labora examination, including a blood count. The patient should not exc recommended dosage, should be closely supervised and should warned to discontinue the drug and report immediately if fever, s throat, or mouth lesions (symptoms of blood dyscrasia); sudden we gain (water retention); skin reactions; black or tarry stools or o evidence of intestinal hemorrhage occur. Make regular blood cou Discontinue the drug immediately and institute countermeasures if white count changes significantly, granulocytes decrease, or imma forms appear. Use greater care in the elderly and in hypertensi

Adverse Reactions: The most common are nausea, edema and rash. Swelling of the ankles or face may be minimized by withhol dietary salt, reduction in dosage or use of diuretics. In elderly pati and in those with hypertension the drug should be discontinued the appearance of edema. The drug has been associated with pepti

280-lb. tackles—or 108-lb. housewives—Butazolidin alka can hasten recovery from the onizing pain of shoulder bursitis.

not for every patient. Check carefully the Contraindications, Warning and cautions shown below.

l adverse reactions may occur. The most common are nausea, edema and rash. ely, agranulocytosis has been reported. All adverse reactions are listed below, too.

y-for-pay or workaday patients—when they come up with shoulder bursitis and your ical judgment indicates Butazolidin alka—go with it.

l watch the comeback.



nd may reactivate a latent peptic ulcer. The patient should be in-ed to take doses immediately before or after meals or with to minimize gastric upset. Mild drug rashes frequently subside reduction of dosage. However, rash accompanied by fever or systemic reactions usually requires withholding medication. uric rash has also been reported. Agranulocytosis, exfoliative atitis, Stevens-Johnson syndrome, or a generalized allergic re-n similar to serum sickness may occur and require permanent rawal of medication. Stomatitis, salivary gland enlargement, ing, vertigo and languor may occur. Leukemia and leukemoid ions have been reported. While not definitely attributable to the a causal relationship cannot be excluded. Thrombocytopenic ura and aplastic anemia may occur. Confusional states, agitation, ache, blurred vision, optic neuritis and transient hearing loss have reported, as have hyperglycemia, hepatitis, jaundice, and several : of anuria and hematuria. With long-term use, reversible thyroid plasia may occur infrequently. Moderate lowering of the red cell : due to hemodilution may occur. 6509-V(B)R2

Butazolidin® alka

Capsules

100 mg. phenylbutazone
100 mg. dried aluminum hydroxide gel
150 mg. magnesium trisilicate
1.25 mg. homatropine methylbromide

Dosage in painful shoulder: Initial: 3 to 6 capsules daily in 3 or 4 equal doses. Trial period: 1 week. Maintenance dosage should not exceed 4 capsules daily; response is often achieved with 1 or 2 capsules daily.

For complete details, please see full prescribing information.

Geigy Pharmaceuticals
Division of Geigy Chemical Corporation, Ardsley, New York

Geigy



50 Years Ago in the Journal

October 1917

The October 1917 issue of the Journal featured the following scientific articles: "Creeping Eruption," J. L. Kirby-Smith, M.D., Jacksonville; "The Management of Increased Blood Pressure," James V. Freeman, M.D., Jacksonville; "A Few Points in the Treatment of Chronic Gonorrhea," H. A. Mills, M.D., Jacksonville; "Baths in Neurasthenia," John Reeve, M.D., DeLand, and "Tinnitus in Neurasthenia," Frederick J. Walter, M.D., Daytona.

Dr. Kirby-Smith described creeping eruption or larva migrans in considerable detail with accompanying photographs. Concluding that "the idea in view when beginning treatment is to destroy the larva at one sitting," he advocated scraping the epidermis with a sharp scalpel, followed by application of equal parts of tincture of iodine and phenol. According to the author, a secondary measure to consider was freezing with carbon dioxide snow.

In his paper, Dr. Freeman set forth a series of propositions on the management of elevated blood pressure and attempted to support them with statistics from some 67 cases. He concluded that ". . . increased pressures, in themselves, are not necessarily of bad prognosis." In another closing statement, Dr. Freeman wrote, "The uneasiness of the laity over increased blood pressures is but a reflection of the uneasiness in the mind of the profession. We have not yet as a whole learned the real significance of blood pressure."

Dr. Mills, in beginning his paper on gonorrhea, stated his reason for presenting the subject was ". . . on account of the cry of despair we so often hear as to whether this condition . . . can really be cured." He described cases treated successfully with silver nitrate solution through a urethroscope.

Dr. Reeve questioned whether neurasthenia was a state or condition rather than a disease and concluded that it was ". . . beyond a doubt, a psycho-neurosis." Describing it as a ". . . functional exhaustion, or debility, of the tissues, especially those of the nervous system, due primarily to impaired metabolism, and secondarily to autointoxication," Dr. Reeve recommended cold hydrotherapy, the results of which, he wrote, were ". . . almost invariably satisfactory in every respect."

Dr. Walter presented a brief and general discussion of hearing disorders connected with neurasthenia and commented that ". . . the prognosis is dependent upon the relief of the neurasthenia."

In the editorial section of the issue, information appeared that the U. S. Civil Service Commission was seeking qualified doctors of medicine for vacancies as "experts in the prevention of infant mortality" in the Children's Bureau, Department of Labor. Salaries announced for those selected ranged from $2,400 to $3,600 per year.

Gebauer's Ethyl Chloride stops creeping eruption cold





highly magnified drawing of the Ancylostoma Braziliense

Creeping eruption is ugly, uncomfortable, and persistent. And, in Florida, it is seen with considerable frequency.

Creeping eruption is caused by the larvae of the dog and cat hookworm, *Ancylostoma Braziliense*. The larvae of this parasite burrow between the superficial layers of the skin, causing much discomfort and characteristic angry eruptions.

Happily, Gebauer Ethyl Chloride sprayed on the affected area for 30 seconds to one minute will usually kill the offending larvae. In difficult cases, it may be necessary to spray for a period of up to two minutes. Improvement and cure generally follow a comparatively few applications.

Next time you treat creeping eruption, treat it with Gebauer Ethyl Chloride. Also highly effective as a topical anesthetic for minor surgery, as in removal of splinters, incision of boils and whitlows, and to alleviate needle pain. May be used for relief of pain such as first and second degree burns, bee stings, sprains and muscle spasm.

GEBAUER PRODUCTS AVAILABLE AT

CORAL GABLES: Surgical Equipment Co. JACKSONVILLE: Central Medical & Surgical Supply • Hermax Corporation • Medical Supply Co. of Jacksonville • Surgical Supply Co. MIAMI: Amedic Surgical Co. • Florida Physicians Supply • Medical Supply Co. ORLANDO: Anderson Surgical Supply Co. • Medical Supply Co. ST. PETERSBURG: Anderson Surgical Supply Co. SARASOTA: Anderson Surgical Supply Co. TALLAHASSEE: Southeastern Surgical Supply Co. TAMPA: Anderson Surgical Supply Co. • Medical Supply Co. • Southern Surgical Supply Co. • Surgical Equipment Co. of Florida. WEST PALM BEACH: Medical Associates Corp. • Medical Supply Co.

OR YOUR LOCAL PHARMACY

Gebauer's

GEBAUER CHEMICAL COMPANY

9410 St. Catherine Ave. • Cleveland, Ohio 44104



when he just can't sleep

Tuinal®

One-Half Sodium Amobarbital and
One-Half Sodium Secobarbital
supplied in ¾, 1½, and 3-grain Pulvules®



Tuinal helps wakeful patients fall asleep fast, stay asleep all night.

Indications: Tuinal is indicated for prompt and moderately long-acting hypnosis. It is not suitable for continuous daytime sedation.

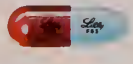
Contraindications: Barbiturates should not be administered to anyone with a history of porphyria, nor should they be given in the presence of uncontrolled pain, because excitement may result.

Warning: May be habit-forming.

Precautions: Tuinal should be used cautiously in patients with decreased liver function, since prolongation of effect may occur.

Adverse Reactions: Idiosyncrasy, such as excitement, hangover, or pain, may appear. Hypersensitivity reactions occur in some patients, especially in those with asthma, urticaria, or angioneurotic edema.

Overdosage: C.N.S. depression. Symptoms—Depression of respiration and of superficial and deep reflexes, slight constriction of the pupils (in severe poisoning, dilation), decreased urine formation, lowered body temperature, coma. Treatment—Symptomatic and supportive (gastric lavage; intravenous fluids; maintenance of blood pressure, body temperature, and adequate respiration). Dialysis may speed removal of barbiturates from body fluids.



Dosage: 50-200 mg. (¾-3 grains) at bedtime.

[031767]

Additional information available to physicians upon request.
Eli Lilly and Company • Indianapolis, Indiana 46206

700955

Lilly



PRICED SO LOW YOU CAN'T SAY NO

Steal an hour, a day, a week—fishing, cruising, lazing. Plenty of room for family and friends. Enclosed cabin, 2 full-length bunks, marine head. Famous Stamas Level Ride in any water, at all speeds. All fiberglass. V-24 Clearwater is trailerable without special permits.

WRITE Dept. F for color brochures and nearest dealer. Stamas Boats are built in Florida; enjoyed all over the world.

Stamas BOATS, INC.
Tarpon Springs, Florida 33589



From a continuing study on nasal congestion . . .



timed to work while your patient does

A study being conducted by the Department of Otolaryngology, Greater Baltimore Medical Center is stockpiling evidence that points to the fast action and prolonged relief effected by Triaminic in the treatment of nasal congestion.

Begun in March 1966, the study to date has encompassed 85 patients with common nasal disorders—and measured their response to recommended doses of Triaminic tablets.

Timed to release its oral nasal decongestant and two antihistamines within 8 hours, Triaminic was found to effect partial or complete relief in better than 82% of the subjects treated. Clearing nasal obstruction. Reducing turbinate swelling. Making breathing easier.

It's a comforting thing to know that Triaminic *really* works.

Triaminic® *timed-release tablets*

Each timed-release tablet contains:

Phenylpropanolamine hydrochloride 50mg. Pyrilamine maleate 25mg. Pheniramine maleate 25mg.

Side effects: Occasional drowsiness, blurred vision, cardiac palpitations, flushing, dizziness, nervousness or gastrointestinal upsets.

Precautions: The patient should be advised not to drive a car or operate dangerous machinery if drowsiness occurs. Use with caution in patients with hypertension, heart disease, diabetes or thyrotoxicosis.

DORSEY LABORATORIES • *a division of The Wander Company* • **LINCOLN, NEBRASKA** 68501

Wounds, abscess, cellulitis



...and the complications of staph.

From time of birth, the child is exposed to a whole range of potential staph infections: wounds; secondarily infected dermatoses; primary lesions, such as deep impetigo (ecthyma), boils and felons; and more serious conditions such as osteomyelitis, staph pneumonia and staph meningitis.

Bactericidal

Hardly a staph organism can resist the bactericidal action of Prostaphlin® (sodium oxacillin), as shown by a 34-month *in vitro* study. Of all staph isolates tested, 99.5% were sensitive to oxacillin.[1]

Clinically Proven

There is a high correlation between these *in vitro* findings and clinical results. Of 610 patients treated with Prostaphlin (sodium oxacillin), 89.8% were reported cured or improved, including those with staph infections resistant to penicillin G.[2] And since resistance does not appear to develop *in vivo,* therapy with oxacillin can be extended when necessary.

Outstanding Safety Record

Besides being staph-specific and rapidly absorbed—Prostaphlin (sodium oxacillin) has established an outstanding record of safety during five years of widespread clinical use. Continuous high blood levels of oxacillin have not produced toxic effects on kidney function, assuring a significant margin of safety. However, as with all penicillins, the possibility of allergic response should be considered.

Capsules, Oral Suspension and Injectable

Prostaphlin (sodium oxacillin) is available in three flexible dosage forms to suit the age of the patient and severity of infection—an oral solution for pediatric use, capsules, and multi-dose vials for injection.

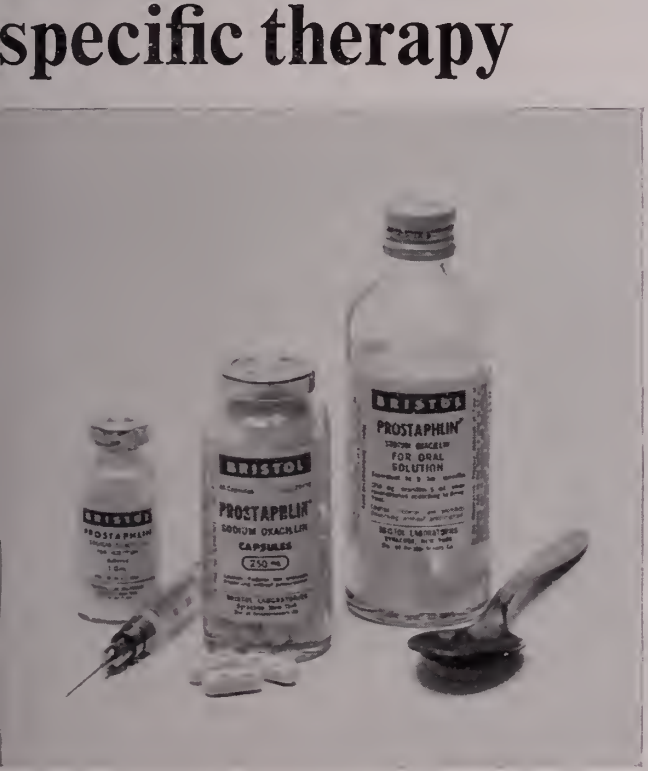
PRESCRIBING INFORMATION: For complete information, consult Official Package Circular. *Indications:* Infections caused by Staphylococci, particularly those due to penicillin G-resistant Staphylococci. *Contraindications:* A history of severe allergic reactions to penicillin. *Precautions:* Typical penicillin-allergic reactions may occur. Safety for use in pregnancy and premature infants is not established. Because of limited experience, use cautiously and evaluate organ system function frequently in neonates. Mycotic or bacterial superinfections may occur. Assess renal, hematopoietic and hepatic function intermittently during long-term therapy. *Adverse Reactions:* Skin rashes, pruritus, urticaria, eosinophilia, nausea, vomiting, diarrhea, fever and occasional anaphylaxis. Rare cases of reversible hepatocellular dysfunction have occurred. Moderate SGOT elevations have been noted. Thrombophlebitis has occurred occasionally during intravenous therapy and leukopenia was noted in two cases. *Usual Oral Dosage:* Adults: 500 mg. *q.* 4 or *q.* 6 *h.* Children: 50 mg./Kg./day. *Usual Parenteral Dosage:* Adults: 250-500 mg. *q.* 4 or *q.* 6 *h.* Children: 50 mg./Kg./day. Treat beta-hemolytic streptococcal infections for at least 10 days. Give oral drug 1 to 2 hours before meals. *Supplied:* Capsules—250 and 500 mg. in bottles of 48. Injectable—250 mg., 500 mg., and 1 Gm. dry filled vial for I.M./I.V. use. For Oral Solution—100 ml. bottle, 250 mg./5 ml. when reconstituted. **A.H.F.S. CATEGORY 8:12.16**

References: 1. Abstracted from *Antibiotic Sensitivity of Staphylococci Studied from November 1962 through August 1965,* reported by Griffith, L.J., Staphylococcus Reference Laboratory, V.A. Hospital, Batavia, N.Y. 2. Data on file, Bristol Laboratories.

BRISTOL

BRISTOL LABORATORIES/Division of Bristol-Myers Co., Syracuse, N.Y.

Staph reliably controlled with specific therapy



A suitable dosage form for every staph situation

Whenever you suspect staph PROSTAPHLIN®

SODIUM OXACILLIN

Professional Courtesy

This Statement on Professional Courtesy was adopted by the American Medical Association Judicial Council, June 17, 1967:

The custom of professional courtesy embodies the ancient tradition of fraternalism among physicians in the art which they share, and their mutual concern to apply their learning for the benefit of one another as well as their patients. The Judicial Council reaffirms and endorses the principle of professional courtesy as a noble tradition that is adaptable to the changing scene of medical practice.

Professional courtesy is not a rule of conduct that is to be enforced under threat of penalty of any kind. It is the individual responsibility of the physician to determine for himself and within his own conscience to whom and the extent to which he shall allow a discount from his usual and customary fees for the professional services he renders, and to whom he shall render such services without charge as professional courtesy.

The following guidelines are offered as suggestions to aid physicians in resolving questions related to professional courtesy.

1. Where professional courtesy is offered by a physician but the recipient of services insists upon payment, the physician need not be embarrassed to accept a fee for his services.

2. Professional courtesy is a tradition that applies solely to the relationship that exists among physicians. If a physician or his dependents have insurance providing benefits for medical or surgical care, a physician who renders such service may accept the insurance benefits without violating the traditional ethical practice of physicians caring for the medical needs of colleagues and their dependents without charge.

3. In the situation where a physician is called upon to render services to other physicians or their immediate families with such frequency as to involve a significant proportion of his professional time, or in cases of long-term extended treatment, fees may be charged on an adjusted basis so as not to impose an unreasonable burden upon the physician rendering services.

4. Professional courtesy should always be extended without qualification to the physician in financial hardship, and members of his immediate family who are dependent upon him.



Ballast Point Manor

5226 Nichols St., P. O. Box 13467 Phone 831-4191
Tampa, Florida

Don Savage, Owner-Manager

Care of mild mental cases, senile disorders and invalids. Alcoholics treated. Aged adjudged cases will be accepted on either permanent or temporary basis.

A breakthrough in the control of pain

Talwin®

brand of

pentazocine

(as lactate)

**a potent injectable non-narcotic—
may be used in place of morphine
and other narcotic analgesics**



A breakthrough in the control of pain

Talwin®

brand of

pentazocine

(as lactate)

a potent injectable non-narcotic—may be used in place of morphine and other narcotic analgesics

Talwin 30 mg. relieves pain usually as quickly and effectively as morphine 10 mg.*

whatever the intensity of the pain

whatever the cause of the pain

whatever the site† of the pain

whatever the chronicity of the pain

whatever the age†† of the patient

without the liability of narcotics

without the development of tolerance on prolonged use

with less risk of severe respiratory depression than with morphine

with less constipation

with less urinary retention

Clinical experience of more than 150 investigator with over 12,000 patients given varying dosages o Talwin shows that this potent injectable analgesi is not a narcotic.

Talwin has less risk of severe respiratory depres sion, urinary retention, and constipation than mo phine—a great boon for postsurgical patients.

Talwin produces less nausea, vomiting and dia phoresis than meperidine.

Constipation and urinary retention are seldom problem with Talwin.

Very rarely do hallucinations or disorientation oc cur (0.1% each).

No significant hepatic, renal, hematopoietic or neu rologic disturbances have been reported.

Talwin is well tolerated even by the aged or very patients.

Used during active labor, its tolerance by th mother and newborn is comparable to meper dine's. As with all new drugs, Talwin should be use with caution in pregnant women and in women de livering premature infants.

Tolerance to the analgesic effect of Talwin has no developed with prolonged use.

Talwin gives significant relief of pain in from 15 t 20 minutes following I.M. or S.C. injection.

Talwin relieves pain usually for 3 hours or longe with a single injection; however, the duration ma sometimes be less than with morphine.

*Its duration of action may sometimes be less than that of morphine.

†Should not be used for patients with increased intracranial pressure, head injury or pathologic brain conditions.

††Until sufficient experience is gained, Talwin should not be administered to children under 12 years of age.

86 per cent of medical and surgical patients obtained excellent to good relief with Talwin 30 mg. administered parenterally

Talwin

brand of pentazocine (as lactate)

used for pain of all types

Talwin has a wide range of usefulness in surgery

Types of surgical use	Number of patients	Efficacy				
		% Exc.	% Good	Exc. + Good	% Fair	% Poor
• Preoperative	118	31	52	83%	15	2
• Postoperative	914	58	28	86%	8	6
• Pre- and postoperative	12	75	17	92%	0	8
• Minor surgery	33	30	39	69%	0	31
• Traumatic	14	64	29	93%	7	0
• Dental	33	67	24	91%	3	6
Total patients.. 1124						

Efficacy of 30 mg. Talwin I.M. and S.C. as related to types of surgical use in a cooperative study

Data in files of Department of Medical Research, Winthrop Laboratories.

High incidence of poor results in minor surgery is due primarily to one study involving change of burn dressings in children; 9 of 19 patients obtained poor results with dose used.

Talwin relieves all types of pain in acute and chronic medical disorders

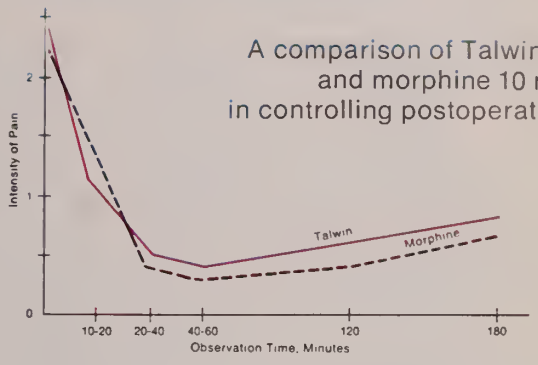
Type of medical pain	Number of patients	Percentage of relief				
		Excellent	Good	Exc. + Good	Fair	Poor
• Malignancy, pain in	161	44	37	81%	8	11
• Orthopedic; see also "Arthritis"	111	53	38	91%	5	4
• Cardiovascular pain; see also "Miscellaneous medical"	96	59	27	86%	6	7
• Genitourinary pain	83	42	33	75%	16	10
• Arthritis	76	33	51	84%	12	4
• Gynecologic pain	35	57	34	91%	6	3
• Cephalalgia	21	45	41	86%	9	5
• Gastrointestinal pain	19	89	5	94%	0	5
• Chest, including • Pleurisy • Pulmonary embolism and infarct • Lung abscess	12	83	17	100%	0	0
• Miscellaneous medical, including • Peripheral vascular disease • Thrombophlebitis • Cervical root pain • Facial neuralgia • Syringomyelia • Burns	108	50	39	89%	9	2
Total patients.....722						

Efficacy of 30 mg. Talwin I.M. and S.C. as related to types of medical pain in a cooperative study

Data in files of Department of Medical Research, Winthrop Laboratories.

See next page for additional product information

Talwin relieves pain as quickly as morphine



A comparison of Talwin 30 mg. and morphine 10 mg. I.M. in controlling postoperative pain*

Figure 1.

Talwin 30 mg. proved equivalent to morphine 10 mg. in overall analgesic efficacy. During the early postmedication period (up to 40 minutes after drug injection), Talwin was superior in effect to morphine.

After observation periods ranging from 40 to 180 minutes there was no difference between the drugs in their effect on intensity. There were 141 and 119 complete patient records for Talwin and morphine, respectively, in this double-blind study. Other clinical investigators, studying duration, state that relief with Talwin may be obtained for up to three hours or longer, a period sometimes less than morphine's.

Talwin is as effective for severe pain (Fig. 2) as for moderate pain (Fig. 3)†

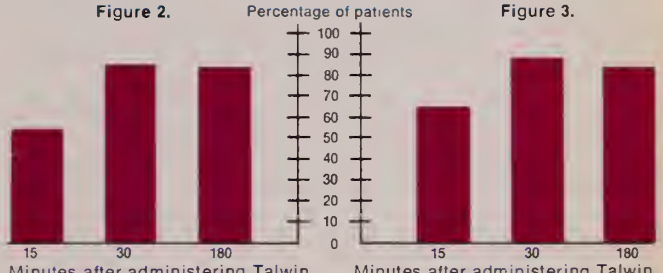


Figure 2.

Per cent excellent to good relief of severe pain obtained with 30 mg. Talwin in 218 postoperative patients

Figure 3.

Per cent excellent to good relief of moderate pain obtained with 30 mg. Talwin in 203 postoperative patients

Talwin does not require a narcotics prescription or narcotics records

The World Health Organization Expert Committee on Dependence-Producing Drugs concluded that "...there was no need at this time for narcotics control of pentazocine [Talwin] internationally or nationally."‡

*Storer, E. H.: Data in the files of the Sterling-Winthrop Research Institute.

†Cooperative study, data in the files of the Department of Medical Research, Winthrop Laboratories.

‡*World Health Organization Technical Report Series*, No. 343, 1966, p. 6

A breakthrough in the control of pain

Talwin®

brand of

pentazocine

(as lactate)

a potent injectable non-narcotic—may be used in place of morphine and other narcotic analgesics

Contraindications: *Increased Intracranial Pressure, Head Injury, or Pathologic Brain Conditions in which clouding of sensorium is undesirable.* Talwin (brand of pentazocine) should not be administered in these cases, since drug-induced sedation, dizziness, nausea, or respiratory depression could be misleading.

Precautions: *Pregnancy.* No teratogenic or embryotoxic effects attributable to the use of Talwin have been seen in extensive reproductive studies in animals; however, like all new drugs, Talwin should be given with caution to pregnant women. A large number of patients in labor have received the drug with no adverse reactions other than those that occur with commonly used strong analgesics. However, as with other strong analgesics, Talwin should be used with caution in women delivering premature infants.

Ambulatory Patients. Since sedation, dizziness, and occasional euphoria have been noted, ambulatory patients should be warned not to operate machinery, drive cars, or unnecessarily expose themselves to hazards.

Certain Respiratory Conditions. The possibility that Talwin (brand of pentazocine) may cause respiratory depression should be considered in treatment of patients with bronchial asthma. Talwin should be administered only with caution and in low dosage to patients with respiratory depression (e.g., from other medication, uremia, or severe infection), obstructive respiratory conditions, or cyanosis.

Patients Dependent on Narcotics. Because Talwin is a narcotic-antagonist, patients dependent on narcotics and receiving Talwin may occasionally experience certain withdrawal symptoms. Talwin should be given with special caution to such patients. It has been observed that some patients previously given narcotic-analgesics for one month or longer had mild withdrawal symptoms when the drug was replaced with the analgesic, Talwin. After a short period of adjustment the subjects were usually able and willing to continue taking Talwin, and relief of pain was satisfactory.

Nonaddicted Patients Receiving Narcotics. Symptoms believed to be indicative of antagonism to the opiate may be observed rarely with administration of Talwin to patients receiving opiates for a short time. Intolerance or untoward reactions are seldom observed after administration of Talwin to patients who have received single doses or who have had limited exposure to narcotics.

Impaired Renal or Hepatic Function. Although laboratory tests have not indicated that Talwin (brand of pentazocine) causes or increases renal or hepatic impairment, the drug should be administered with caution to patients with such impairment. Extensive liver disease appears to predispose to greater side effects (e.g., marked apprehension, anxiety, dizziness, sleepiness) from the usual clinical dose, and may be the result of decreased metabolism of the drug by the liver.

Myocardial Infarction. As with all drugs, Talwin (brand of pentazocine) should be used with caution in patients with myocardial infarction who have nausea or vomiting.

Biliary Surgery. Until further experience is gained with the effects of Talwin on the sphincter of Oddi, the drug should be used with caution in patients about to undergo surgery of the biliary tract.

Adverse Effects: Talwin is relatively free from the undesirable side effects associated with morphine, such as constipation, urinary retention, or severe respiratory depression. Furthermore, Talwin produces less nausea, vomiting, and diaphoresis than meperidine.

In over 12,000 patients who received Talwin intramuscularly, subcutaneously, or intravenously, nausea, the most frequent adverse effect, occurred in approximately 5.0 per cent. In decreasing order of occurrence were vertigo, dizziness or lightheadedness; vomiting; and euphoria. Respiratory depression was reported as an adverse reaction in 1.0 per cent.

The incidence of each of the other adverse effects was well below 1.0 per cent: constipation, circulatory depression, diaphoresis, urinary retention, alteration in mood (nervousness, apprehension, depression, floating feeling), hypertension, sting on injection, headache, dry mouth, flushed skin including plethora, altered uterine contractions during labor, dermatitis including pruritus, dreams, paresthesia, and dyspnea occurred rarely after administration of Talwin (brand of pentazocine). Furthermore, each of the following adverse reactions occurred in less than 0.1 per cent: tachycardia, visual disturbance (blurred vision, diplopia and nystagmus), hallucinations, disorientation, weakness or faintness, muscle tremor, chills, allergic reactions including edema of the face, taste alteration, insomnia, diarrhea, cramps, and miosis; laryngospasm in one patient.

Talwin has not produced severe respiratory embarrassment in adults (never apnea), even with large amounts. A small number of newborn infants whose mothers received Talwin during labor had transient apnea. The incidence of temporary diminution in the rate or strength of uterine contractions is low after administration of Talwin, similar to that following meperidine hydrochloride. (In reporting no interference with normal labor in patients receiving Talwin, one investigator further stated that the drug may increase uterine activity.) Generally, no significant fetal heart rate change occurs.

Laboratory tests of blood and of liver and kidney functions have revealed no significant abnormalities. A minimum and probably insignificant increase in the per cent of eosinophils in peripheral blood counts and bone marrow occurred occasionally.

Talwin is well tolerated by patients with diabetes mellitus, and no changes in insulin requirements have been observed.

Dosage and Administration: *Adults, Excluding Patients in Labor.* Average recommended single parenteral dose is 30 mg., by intramuscular, subcutaneous, or intravenous route; may be repeated every three to four hours. Pain has been relieved in most patients with not more than three doses daily. Infrequently, selected patients have received single doses as high as 60 mg.

Patients in Labor. A single, intramuscular 30 mg. dose has been most commonly administered. An intravenous 20 mg. dose has given adequate pain relief to some patients in labor when contractions become regular, and this dose may be given two or three times at two- to three-hour intervals, as needed.

Children Under 12 Years of Age. Since clinical experience in children under twelve years of age is limited, the use of Talwin (brand of pentazocine) in this age group is not recommended.

Duration of Therapy. Patients with chronic pain who received Talwin for prolonged periods (e.g., over 300 days) experienced no withdrawal symptoms even when administration was stopped abruptly; furthermore, there was no tolerance to the analgesic effect.

CAUTION. Talwin should not be mixed in the same syringe with soluble barbiturates because precipitation will occur.

Treatment of Overdosage or Respiratory Depression. Talwin has not produced apnea or severe respiratory embarrassment in adults, even in large doses. Occasionally, however, moderate respiratory depression may occur. Means of maintaining proper oxygenation should be available in case of overdosage or respiratory depression, and methylphenidate (Ritalin®) should be administered parenterally. The usual narcotic-antagonists, such as nalorphine, are not effective respiratory stimulants for depression due to Talwin.

How Supplied: Ampuls of 1 ml., containing Talwin® (pentazocine) as lactate equivalent to 30 mg. base and 2.8 mg. sodium chloride, in Water for Injection. **Boxes of 10, 25, and 100.**

Multiple dose vials of 10 ml., each 1 ml. containing Talwin® (pentazocine) as lactate equivalent to 30 mg. base, 2 mg. acetone sodium bisulfite, 1.5 mg. sodium chloride, and 1 mg. methylparaben as preservative, in Water for Injection. **Boxes of 1.**

The pH of Talwin solutions is adjusted between 4 and 5 with lactic acid and sodium hydroxide.

Winthrop

Winthrop Laboratories, New York, N.Y. 10016

PRINTED IN U.S.A. ISSUED AUGUST, 1967 (1035M)

DIARRHEA



CANTIL®
(mepenzolate bromide)

Diarrhea, one of the most vexing symptoms of common G. I. disorders can often be curbed with Cantil (mepenzolate bromide), bringing welcome relief to the harassed patient. Relatively specific for the hyperactive colon, it helps reduce diarrhea, pain and spasm with minimal effect on other viscera. Cantil (mepenzolate bromide) is indicated whenever these symptoms are associated with irritable colon, gastroenteritis, diverticulitis, and mild to moderate ulcerative colitis.

It is an anticholinergic drug without narcotic properties. Side effects are usually mild.

LAKESIDE

IN BRIEF: One or two tablets three times a day and one or two at bedtime usually provide prompt relief. Cantil with Phenobarbital may be prescribed if sedation is required.

Dryness of the mouth, blurring of vision, constipation, nausea, vomiting, bloating and dizziness may occur but are usually mild and transitory. Urinary retention is rare. Caution should be observed in prostatic hypertrophy — withhold in glaucoma. Contraindicated in patients sensitive to phenobarbital and/or Cantil (mepenzolate bromide); in toxic megacolon, obstruction of G. I. or G. U. tract.

SUPPLIED: CANTIL (mepenzolate bromide) — 25 mg. per scored tablet. Bottles of 100 and 250. CANTIL with PHENOBARBITAL — containing in each scored tablet 16 mg. phenobarbital (warning: may be habit forming) and 25 mg. mepenzolate bromide. Bottles of 100 and 250.

LAKESIDE LABORATORIES, INC., Milwaukee, Wisconsin 53201



"George wants to know if it's okay to take his cold medicine now, Doctor, instead of seven o'clock?"



The long-continued action of Novahistine LP should help you both get a good night's sleep. Two tablets in the morning and two in the evening will usually provide round-the-clock relief by helping clear congested air passages for freer breathing. Novahistine LP also helps restore normal mucus secretion and ciliary activity—normal physiologic defenses against infection of the respiratory tract. Use cautiously in individuals with severe hypertension, diabetes mellitus, hyperthyroidism or urinary retention. Caution ambulatory patients that drowsiness may result. Each Novahistine LP tablet contains: phenylephrine hydrochloride, 25 mg., and chlorpheniramine maleate, 4 mg.

NOVAHISTINE® LP

DOW **PITMAN-MOORE** Division of The Dow Chemical Company, Indianapolis

Pediatric Care Center, Inc.
of Broward County, Florida

A Non-Profit Home for Mentally Retarded, Emotionally and Physically Handicapped Children.

Licensed by the Florida State Board of Health

Licensed M.D. On Call 24 Hours a Day

Clinical Psychologist Available

For information write or call:

Ann Storck, R.N., F.A.A.M.D.
Executive Director
901 N.W. Ninth Avenue
Fort Lauderdale, Florida 33311
Telephone (305) 522-6934

National and Regional Meetings in Florida

October

American Association of Public Health Physicians, Miami Beach, Oct. 23-27.

American Orthotics and Prosthetics Association, Fontainebleau Hotel, Miami Beach, Oct. 7-11.

American Public Health Association, Fontainebleau Hotel, Miami Beach, Oct. 23-27.

American School Health Association, Miami, Oct. 21-26.

November

Gerontological Society, Princess Martha Hotel, St. Petersburg, Nov. 9-11.

Southern Medical Association, Miami Beach, Nov. 13-16.

National Federation of Catholic Physicians' Guild, Miami, Nov. 9-11.

Management of Trauma and Disaster Medical Problems, Carillon Hotel, Miami Beach, Nov. 10-11.

HIGHLAND HOSPITAL

ASHEVILLE, NORTH CAROLINA

Founded 1904

A DIVISION OF THE DEPARTMENT OF PSYCHIATRY
OF DUKE UNIVERSITY

Accredited by the Joint Commission on Accreditation and Certified for Medicare

Complete facilities for evaluation of and intensive treatment of psychiatric patients, including individual psychotherapy, group therapy, psychodrama, electro-convulsive therapy, Indoklon convulsive therapy, drugs, social service work with families, family therapy, and an extensive and well organized activities program, including occupational therapy, art therapy, athletic activities and games, recreational activities and outings. The treatment program of each patient is carefully supervised in order that the therapeutic needs of each patient may be realized.

Complete modern facilities with 85 acres of landscaped and wooded grounds in the City of Asheville.

Brochures and information on financial arrangements available
Contact: Mrs. Elizabeth Harkins, ACSW, Coordinator of Admissions

or

Charles W. Neville, Jr., M.D.
Assistant Professor of Psychiatry and Medical Director
Area Code 704 - 253-2761

Night Leg Cramps . . . Unwelcome Bedfellow

In Diabetes[1], Arthritis[2], and Peripheral Vascular Disorders[2]



now . . . specific therapy for night leg cramps

Walker

QUINAMM™

Consistently effective, QUINAMM provided complete relief in 94% of 200 patients studied, many of whom were severe cases refractory to other medication.[3] Your prescription for one tablet at bedtime often controls painful night cramps with the initial dose . . . helps restore restful sleep.

THE NATIONAL DRUG COMPANY
DIVISION OF RICHARDSON MERRELL INC
PHILADELPHIA, PENNSYLVANIA 19144

Prescribing Information: Composition: Each white, beveled, compressed tablet contains: Quinine Sulfate 260 mg. and Aminophylline 195 mg. **Contraindication:** QUINAMM is contraindicated in pregnancy because of its quinine content. **Precautions:** Aminophylline may produce intestinal cramps in some instances, and quinine may produce symptoms of cinchonism, such as tinnitus, dizziness, and gastrointestinal disturbance. Discontinue use if ringing in the ears, deafness, skin rash, or visual disturbances occur. **Dosage:** One tablet upon retiring. Where necessary, dosage may be increased to one tablet following the evening meal and one tablet upon retiring. **Supplied:** Bottles of 100 and 500 tablets.

References: 1. Shuman, C.: Am. J. Med. Sci., 225:54, 1953. 2. Perchuk, E., et al.: Angiology, 12:102, 1961. 3. Rowls, W., et al.: Med. Times, 87:818, 1959.

6/67 Q-706A

When the agitated geriatric disrupts the home...

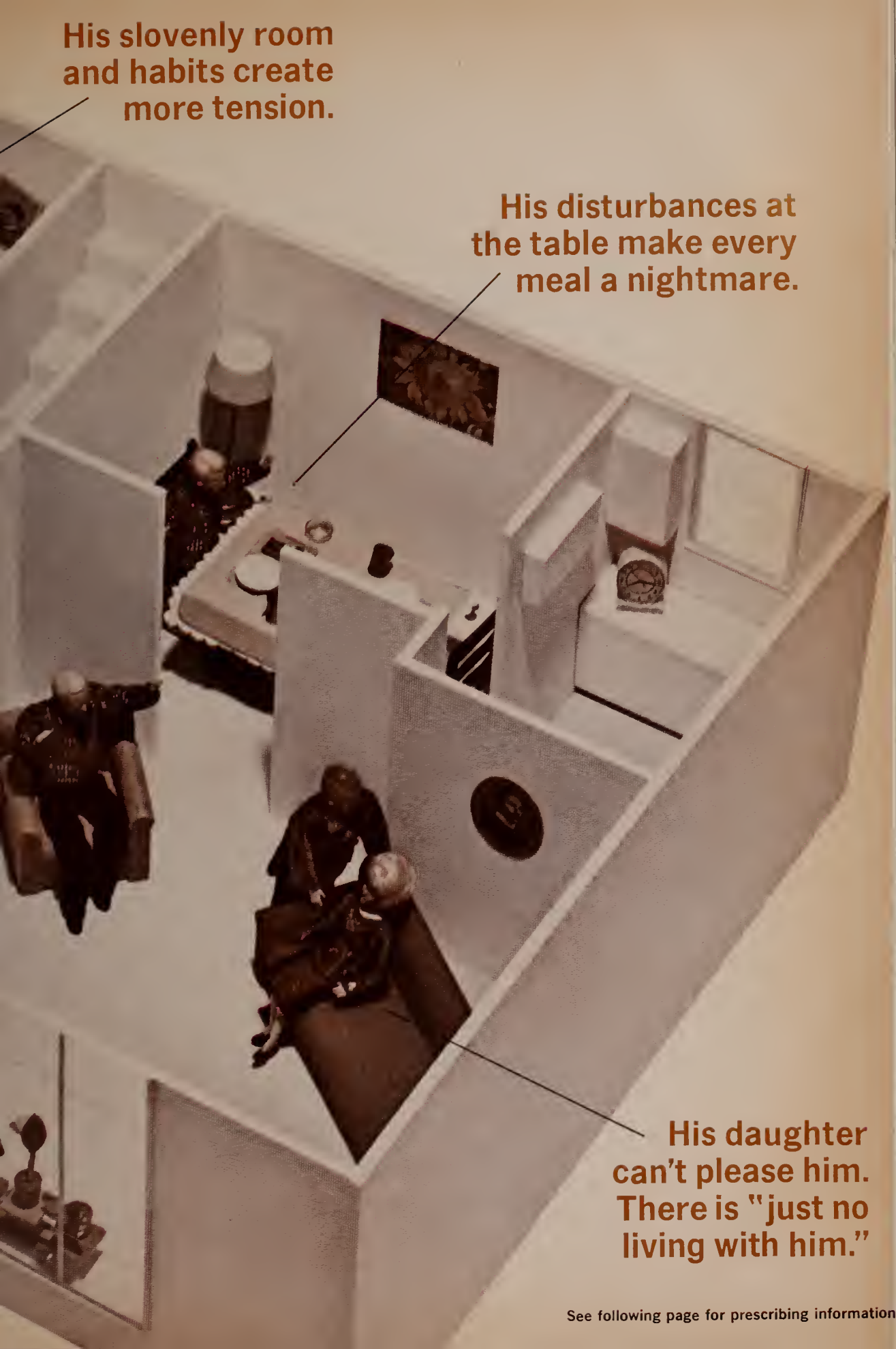
His teen-age granddaughter won't invite friends home because of his outbursts.



for moderate to severe anxiety

Mellaril®
(thioridazine)
25 mg. t.i.d.

SANDOZ



See following page for prescribing information

When the agitated geriatric disrupts the home...

Anxiety that seriously interferes with the individual's performance at work, at home, or in the community may be regarded as *moderate* to severe in degree.

Mellaril often recommends itself to the treatment of moderate to severe anxiety because it

- helps control the most frequent symptoms: marked tension, agitation, apprehension, restlessness, hypermotility
- often alleviates anxiety-induced somatic complaints
- frequently helps strengthen emotional resources
- helps the patient maintain realistic contact with environment, closer harmony with family

Thus, when you consider the anxiety moderate to severe ... consider Mellaril.

Contraindications: Severely depressed or comatose states from any cause, and in association with or following MAO inhibitors; severe hypertensive or hypotensive heart disease.

Precautions: Hypersensitivity reactions (e.g., leukopenia, agranulocytosis) and convulsive seizures are infrequent. Pigmentary retinopathy has been observed where doses in excess of those recommended were used for long periods of time. May potentiate central nervous system depressants, atropine, and phosphorus insecticides. Where complete mental alertness is required, administer the drug cautiously and increase dosage gradually. In addition, orthostatic hypotension (especially in female patients) has been observed. Epinephrine should be avoided in treatment of drug-induced hypotension.

Side Effects: Pseudoparkinsonism and other extrapyramidal disorders are infrequent; drowsiness, especially in high doses early in treatment, may occur; nocturnal confusion, dryness of the mouth, nasal stuffiness, headache, peripheral edema, lactation, galactorrhea, and inhibition of ejaculation are noted on occasion; photosensitivity and other allergic skin reactions may occur but are extremely rare.

Before prescribing, see package insert for full product information.

For moderate to severe anxiety

Mellaril®
(thioridazine)
25 mg. t.i.d.

SANDOZ

mudrane®

for

- EMPHYSEMA
- ASTHMA
- CHRONIC BRONCHITIS
- BRONCHIECTASIS

The fast-disintegrating uncoated tablet gives relief in 15 minutes

Each tablet contains:

Potassium Iodide	195 mg.
Aminophylline	130 mg.
Phenobarbital, Caution: May be habit forming...	21 mg.
Ephedrine HCl	16 mg.

FEDERAL LAW PROHIBITS
DISPENSING WITHOUT PRESCRIPTION

Precautions: Usual for aminophylline-ephedrine-phenobarbital. Iodides may cause nausea, long use may cause goiter. Discontinue if symptoms of iodism develop.

Iodide contraindications: tuberculosis, pregnancy.

DOSAGE

One tablet, with full glass of water, 3 or 4 times daily.

Dispensed in bottles of 100 and 1000 tablets.

MUDRANE GG—Formula, dosage and package identical to Mudrane—*except*—100 mg. glyceryl guaiacolate replaces the potassium iodide. The value of Mudrane cannot be enjoyed by a small group in which K.I. is contraindicated. Mudrane GG is prepared for this group.

MUDRANE GG ELIXIR—Four 5 cc teaspoonfuls is equivalent to one Mudrane GG tablet. Dosage adjusted to age and weight of child. Mudrane GG Elixir is for pediatric patients and those who think they cannot swallow tablets. Dispensed in pint and half gallon bottles.

WM. P. POYTHRESS & CO., INC.
RICHMOND, VIRGINIA 23217
Manufacturers of ethical pharmaceuticals since 1856

Before prescribing, see complete prescribing information in SK&F literature or *PDR*. A brief precautionary statement follows.
Contraindications: Glaucoma, prostatic hypertrophy, stenosing peptic ulcer, pyloroduodenal obstruction, or bladder neck obstruction.
Precautions: Use cautiously in the presence of hypertension, hyperthyroidism, coronary artery disease; warn vehicle or machine operators of possible drowsiness.
Usage in Pregnancy: Use cautiously, especially in the first trimester. *Note:* The iodine in isopropamide iodide may alter PBI test results and will suppress I^{131} uptake; discontinue 'Ornade' one week before these tests.
Adverse Reactions: Drowsiness; excessive dryness of nose, throat or mouth; nervousness; insomnia. Other known possible side effects of the individual ingredients: nausea, vomiting, diarrhea, rash, dizziness, fatigue, tightness of chest, abdominal pain, irritability, tachycardia, headache, difficulty in urination. Thrombocytopenia, leukopenia and convulsions have been reported but no causal relationship has been established.

a stuffy nose is no laughing matter

Ornade® Trademark

Each capsule contains 8 mg. of Teldrin® (brand of chlorpheniramine maleate), 50 mg. of phenylpropanolamine hydrochloride, and 2.5 mg. of isopropamide, as the iodide.

Spansule® Capsules

brand of sustained release capsules

each one can give him all-day or all-night relief



SK&F Smith Kline & French Laboratories

Thomas B. Slade | Fifty Years in Florida | J. Beatty Williams

Surgical SUPPLY COMPANY

HAMILTON — RITTER — SKLAR — BURDICK
CLAY-ADAMS — B-D — BARD-PARKER — TYCOS
BAUM — WELCH-ALLYN AND MANY, MANY OTHERS

Ph. 355-8391 | P. O. Box 2580 — 1050 W. Adams Street | Jacksonville, Fla. 32203



P. L. DODGE MEMORIAL HOSPITAL

M. G. Isaacson, M.D.
Medical Director
1861 N.W. South River Drive
Miami, Florida
Phone 379-1448

A nonprofit-voluntary hospital for the treatment of nervous and mental disorders and the problems of drug addiction and alcoholic habituation. Modern diagnostic and treatment procedures including—Psychotherapy, Insulin, & Electroshock, when indicated. Adequate facilities for recreation and out-door activities. Admissions are made without regard to race, color or national origin.

Information on request
Member NAPPH, American Psychiatric Assn., & American Hospital Assn.

TUCKER HOSPITAL, INC.

212 West Franklin Street
Richmond, Virginia

A private hospital for diagnosis and treatment of psychiatric and neurological disorders. Hospital and out-patient services.

James Asa Shield, M.D.
George S. Fultz, Jr., M.D.
Catherine T. Ray, M.D.

Weir M. Tucker, M.D.
Edward W. Gamble, III, M.D.
Gerald W. Atkinson, M.D.



The meaningful pause. The energy it gives. The bright little lift. Coca-Cola with its never too sweet taste, refreshes best. Helps people meet the stress of the busy hours. This is why we say things go better with Coke TRADE-MARK®

APPALACHIAN HALL

ASHEVILLE Established 1916 NORTH CAROLINA



An Institution for the diagnosis and treatment of Psychiatric and Neurological illnesses, rest, convalescence, drug and alcohol habituation.

Insulin Coma, Electroshock and Psychotherapy are employed. The Institution is equipped with complete laboratory facilities including electroencephalography and X-ray.

Appalachian Hall is located in Asheville, North Carolina, a resort town, which justly claims an all around climate for health and comfort. There are ample facilities for classification of patients, rooms single or en suite.

Wm. Ray Griffin Jr., M.D.
Robert A. Griffin, M.D

Mark A. Griffin Sr., M.D.
Mark A. Griffin Jr., M.D.

Deaths

Bartleson, Fred Durant, Fort Myers; born in Jacksonville, Sept. 19, 1904; Tulane University School of Medicine, 1934; served an externship at Touro Infirmary and a residency at Hope Haven Orphanage, both of New Orleans, La.; came to Fort Myers in 1934 under a preceptorship with Dr. Ernest Bostelman, earning associate and full partnership, and engaged in the private practice of surgery in that city until his death; held membership in the American Medical Association, Southern Medical Association, American Academy of General Practice, International College of Surgeons, International Academy of Proctology and Florida Obstetric and Gynecologic Society; died Apr. 21, 1967, aged 63.

Blalock, Shatteen Taylor, Winter Park; born in Atlanta, Ga., Feb. 23, 1934; Emory University School of Medicine, 1956; served an internship and a residency in internal medicine at the University Hospitals, Oklahoma City, Okla.; engaged in the general practice of medicine in Oklahoma City for three years before coming to Orlando, where she practiced until her death; held membership in the American Medical Association; died May 12, 1967, aged 33.

Borland, James Loudon Sr., Jacksonville; born in Pittsburgh, Pa., Mar. 10, 1907; Harvard Medical School, 1932; interned at Duke University Hospital, Durham, N. C., and served a residency at Johns Hopkins University Hospital, Baltimore, Md.; entered the private practice of gastroenterology in Jacksonville in 1937; served in the U.S. Army Medical Corps from 1942 to 1945, attaining the rank of major, as chief of gastrointestinal diseases, 105th General Hospital, as lecturer on dysentery, Army Tropical Diseases School, Brisbane, Australia, as chief of medicine, Fort Meade Regional Hospital and on the 8th Army Jaundice Commission, Pacific Theatre; was president of the Duval County Medical Society, 1949-1950; served the FMA as a member of the Board of Governors, as chairman and member of the Committee on Postgraduate Education, as a member of the Scientific Committee and as a delegate to the House of Delegates from 1946 to 1963; was a past president and member of the Board of Governors of the American Gastroscopic Society, past president of the Florida State Board of Medical Examiners, chairman of the Gastroenterology Section of the Southern Medical Association, past member of the Board of Directors of Florida Blue Shield and a member of the Committee on Training and Education of the American Gastroenterological Society; was in charge of the gastroenterologic service, St. Vincent's Hospital, St. Luke's Hospital and Duval Medical Center, all of Jacksonville; held membership in the American Medical Association, Southern Medical Association, American Gastroscopic Society, American Gastroenterological Society, Florida Society of Internal Medicine, Jacksonville Hospitals Education Program and was a Fellow of the American College of Physicians; died May 7, 1967, aged 60.

Dowling, Jasper Boswell, Marianna; born in Dale County, Ala., Sept. 15, 1880; University of Nashville Medical Department, 1911; came to Marianna in 1911 and engaged in the private general practice of medicine there until his death; served as president of the Jackson County Medical Society; held membership in the American Medical Association; died June 22, 1967, aged 86.

Horne, Hendly Foxworth, Jacksonville; born in Ludowici, Ga., Dec. 26, 1891; Emory University School of Medicine, 1915; interned at St. Luke's Hospital, Jacksonville, and served a residency at the Southern Pacific Hospital, Galveston, Tex.; returned to Jacksonville where he engaged in the general practice of medicine and surgery until his death; served in the U.S. Army Medical Corps from 1916 to 1917, attaining the rank of captain; made medical history in 1920 at Jacksonville by performing the first successful brain

tumor operation in Florida; was a life member of the FMA; died May 15, 1967, aged 75.

Kafka, Maximillian Martyn, Kendall; born in Warsaw, Poland, Apr. 1, 1900; University of Maryland Medical College, 1924; interned at Bellevue Hospital, N.Y.C.; was first surgical assistant at the A. Roth Ear, Nose and Throat Hospital, N.Y.C.; from 1933 to 1939 held several staff and faculty appointments in N.Y.C.; was commissioned in the U.S. Army Reserve in 1927, became a certified flight surgeon in the U.S. Army Air Force in 1936, entered active service in 1940, was wounded and retired from active duty as a captain in 1941; was awarded Congressional Medal, Selective Service, in 1945; came to Dade County in 1960; held membership in the American Medical Association, International College of Surgeons, American Board of Otolaryngology, American Board of Aviation Medicine, American Aviation Medical Association, was a Diplomate of the American Board of Preventive Medicine, a Fellow of the American College of Preventive Medicine and was founder and president of the American Association of Motor Vehicle Safety; died May 21, 1967, aged 67.

Morse, George Wray, Pensacola; born in Portsmouth, Va., Jan. 2, 1912; University of Virginia Medical School, 1936; interned at Union Memorial Hospital and served residencies at Duval County Hospital and Davis Hospital; served in the U.S. Air Force Medical Corps, attaining the rank of major; was president and vice president and held many committee chairmanships in the Escambia County Medical Society; served the FMA as chairman of the Cancer Control Committee, as chairman of the Surgical Fee Schedule Committee and as a member of the Advisory Committee to the State Welfare Board; held membership in the American Medical Association, Southern Medical Association, Florida Association of General Surgeons, Pensacola Surgical Association and was a Fellow of both the American College of Surgeons and the Southeastern Surgical Congress; died May 10, 1967, aged 55.

Hill Crest
HOSPITAL
(Formerly Hill Crest Sanitarium)

7000 5TH AVENUE SOUTH
Box 2896, Woodlawn Station
Birmingham, Alabama 35212
Phone: 205 - 836-7201

A patient centered independent hospital for intensive treatment of nervous disorders . . .

Hill Crest Hospital was established in 1925 as Hill Crest Sanitarium to provide private psychiatric treatment of nervous or mental disorders. Individual patient care has been the theme during its 42 years of service.

Both male and female patients are accepted and departmentalized care is provided according to sex and the degree of illness.

In addition to the psychiatric staff, consultants are available in all medical specialities.



MEDICAL DIRECTOR:
James A. Becton, M.D., F.A.P.A.

CLINICAL DIRECTORS:
James K. Ward, M.D., F.A.P.A.
Hardin M. Ritchey, M.D., F.A.P.A.

HILL CREST is a member of:
AMERICAN HOSPITAL ASSOCIATION . . .
. . . NATIONAL ASSOCIATION OF PRIVATE PSYCHIATRIC HOSPITALS . . .
ALABAMA HOSPITAL ASSOCIATION . . .
BIRMINGHAM REGIONAL HOSPITAL COUNCIL.
Hill Crest is fully accredited by the Joint Commission on Accreditation of Hospitals.

Hill Crest
HOSPITAL
BIRMINGHAM, ALABAMA

Classified Advertisements

Advertising rates for this column are $5.00 per insertion for ads of 25 words or less. Add 20¢ for each additional word.

physicians wanted

General Practitioners

GENERAL PRACTITIONER WANTED (AAGP) for north Florida college town. Vacancy in busy two man practice in medicine, pediatrics and obstetrics. Immediate excellent income with eventual full partnership. Write C-614, P.O. Box 2411, Jacksonville, Fla. 32203.

EXCELLENT OPPORTUNITY for general practitioner in community of 15,000; central Florida; 76 bed JCAH hospital. Write or call collect R. C. Thompson, Bartow Memorial Hospital, Bartow, Fla.

WANTED: General practitioner associate, leading to partnership. Practice approximately one half industrial. Ideal central Florida community. Send detailed resume to C-716, P.O. Box 2411, Jacksonville, Fla. 32203.

GENERAL PRACTITIONER wanted to take over for physician going into residency. Beach community of 10,000; 50 bed hospital. Office and equipment available. Write C-745, P.O. Box 2411, Jacksonville, Fla. 32203.

WANTED: General practitioner to associate with established young doctor. Also office space available for rent. Contact G. L. Ehringer, M.D., 1184 Oceanshore Blvd., Ormond Beach, Fla. 32074.

GENERAL PRACTITIONER WANTED: Partner, semi-rural practice in central Florida area undergoing rapid industrial expansion. Spacious, fully equipped office including x-ray. Good income without working yourself to death. Write C-749, P.O. Box 2411, Jacksonville, Fla. 32203.

WANTED: Young Florida licensed GP or internist to join three man group in West central Florida. Position permanent with future partnership. Write C-764, P.O. Box 2411, Jacksonville, Fla. 32203.

WANTED: General practitioner or general surgeon to replace physician going to specialize. Good opportunity in ideal central Florida city. Excellent office and equipment. Write C-780, P.O. Box 2411, Jacksonville, Fla. 32203.

Specialists

OBSTETRICIAN-GYNECOLOGIST WANTED: To associate with two man group. Large established practice in Miami; Board eligible or certified; prefer under age 35. Write P.O. Box 384, Miami Shores, Fla. 33153.

PEDIATRICIAN: Forty doctor multi-specialty group in northwest Florida has opening for board qualified pediatrician under age 40. The group would like to add at least two additional pediatricians as soon as possible. Write to Mr. L. L. Smith Jr., P.O. Box 151, Pensacola, Fla. 32502

INTERNIST WANTED: Preferably young board qualified or certified internist to associate with well established certified internist in Ft. Lauderdale, Florida. Terms open. Send details first letter. Write C-752, P.O. Box 2411, Jacksonville, Fla. 32203.

INTERNIST WANTED: Associate for a three man partnership. Board qualified or certified. Located in very actively growing part of metropolitan Atlanta, Georgia area. Full partnership possible in 24 months. Write P.O. Box 506, Marietta, Ga. 30062.

PEDIATRICIAN WANTED: North Dade county. Space available in prestige building. Unusual opportunity for board qualified man. Patient flow in building guarantees instant practice. Inquire Mrs. Brecher, 17301 N.W. 27th Ave., Miami 33054.

ANESTHESIOLOGIST: New facility 100 beds has opening for anesthesiologist on its medical staff. Call or write Administrator or Fred H. Albee, M.D., Chief of Staff, Ormond Beach Memorial Hospital, Box 187, Ormond Beach, Fla. 32074.

INTERNIST NEEDED: Retiring next year. Need capable associate to take over busy practice and office. Terms open. Ft. Lauderdale, Fla. Write full details to C-778, P.O. Box 2411, Jacksonville, Fla. 32203.

EXPANDING MULTISPECIALTY CLINIC in Florida needs gastroenterologist, neurosurgeon, orthopedist, otolaryngologist, urologist. Seven man group, state capitol, two universities, 70,000 population. One hour drive to Panama City resort, beautiful rolling hills. Adequate salary first year then partnership. Will equip office. 250 bed hospital 500 ft. away. Resumé to Dr. Gerald N. Bryant, Medical Arts Clinic, Tallahassee, Fla. 32303.

OPHTHALMOLOGIST: Board certified with Florida license seeking association with ophthalmologist in practice. Age 42. Write C-781, P.O. Box 2411, Jacksonville, Fla. 32203.

OPPORTUNITY FOR DOCTORS who want to join a multi-specialty group—who want to practice in Florida. A senior surgeon with a large practice and with adequate facilities including laboratory, x-ray and physical therapy departments, desires to confer with board eligible or board certified doctors. The intent is to form a new multi-specialty group practice. Close proximity to a new 500 bed hospital. All inquiries held in strict confidence. Reply to: Jay S. Lombardy & Associates, Management to the Medical Profession, 1177 N.E. 8th St., Delray Beach, Fla. 33444.

INDUSTRIAL: Established clinic needs physician with some surgical and orthopedic training. Eventual partnership anticipated. Write The Mitchell Clinic, 241 W. Ashley St., Jacksonville, Fla. 32202.

INTERNIST or GENERAL PRACTITIONER wanted to join medical group or share space in suburban Miami. Write C. F. Lester, M.D., 8988 Bird Rd., Miami, Fla. 33165.

Miscellaneous

WANTED: Full time resident physicians. Contact Administrator, St. Mary's Hospital, West Palm Beach, Florida for particulars.

WANTED: Assistant medical director for medium size Florida based life insurance company. Prefer physician under 40 with Florida license. Write C-760, P.O. Box 2411, Jacksonville, Fla. 32203.

STAFF PHYSICIANS NEEDED for 500 bed hospital for mental retardation in north Florida. Salary ranges $14,940 to $21,180. Florida license or eligible for Florida license. Write Personnel Manager, Sunland Hospital at Tallahassee, 2323 Phillips Rd., Tallahassee, Fla. 32304.

PSYCHOSOMATIC MEDICINE: Applicants now being considered for six to twelve months. Accredited fellowships in psychosomatic medicine beginning Oct. 1967 or Jan. 1968. Salary $12,000. Other openings also available at $5,000 to $7,000. Apply to John J. Schwab, M.D. or Michael J. Kehoe, M.D., Department of Psychiatry, University of Florida, Gainesville 32601.

situations wanted

WANTED: 32 year old university trained general, thoracic and cardiovascular surgeon, would like association with a group of surgeons or surgeon. Military obligation fulfilled. Available July 1968. Write C-779, P.O. Box 2411, Jacksonville, Fla. 32203.

The Florida Medical Association offers placement assistance through the Physician Placement Service, P.O. Box 2411, Jacksonville 32203. This service is for the use of physicians seeking locations, as well as physicians seeking associates, and is without charge.

real estate

RENTAL PROFESSIONAL SUITES: Modern professional building. Ideal location. Ample parking. 2,250 sq. ft. or any part available. Will design to tenants specifications. 1300 North Federal Highway, Lake Worth, Fla. Phone 582-1760.

OCEAN FRONT HIGH RISE PHYSICIAN'S SUITE. Eight room ocean front physician's suite available August 15. Seventeen story high rise rental apartment building in Daytona Beach (190 units). This suite may be rented furnished or unfurnished. Excellent opportunity. Contact Resident Manager, The Towers Apartments, 2800 North Atlantic Avenue, Daytona Beach, Fla. 32018. Phone 677-8333.

MEDICAL OFFICE SPACE FOR RENT: Have one large space (1,100 sq. ft.) unfinished. Excellent area with large parking space. At present have five physicians and two dentists. Need one more. For information write or call Harry C. Fults, 615 South Missouri, Clearwater, Fla. 33516. Phone 531-4206.

FOR RENT: Private office suite available in new medical-dental professional building in Hollywood, Florida. Will partition to suit. Write Drs. Peretz and Balick, 2630 Hollywood Blvd., Hollywood, Fla. 33020. Phone 923-2403.

FOR RENT OR LEASE: 1,200 sq. ft., seven rooms, corner of Cassett and Appleton. Private parking plus on street. Contact Mr. Vansandt, Jacksonville. Phone 384-2488.

FOR RENT: New professional office, only one on Singer Island. Ready about January. S. F. Holden, Inc., 1265 Plaza Circle, Riviera Beach, Fla. 33404. Phone 842-1441.

practices available

FOR SALE: Internal medicine practice, southeast coastal city, Florida. $90,000 gross. New office building. Complete equipment. Share large suite, lab, x-ray and alternate on call with two young certified internists; but own private practice. New hospital. Retiring. Write C-766, P. O. Box 2411, Jacksonville, Fla. 32203.

AVAILABLE: Otolaryngology office. Immediate occupancy. Ideal location. Excellent opportunity. Capable gross $35,000-$50,000 first year. Owner retiring. Sell or lease. Location excellent for general practice. Write C-746, P.O. Box 2411, Jacksonville, Fla. 32203.

OFFICE AND PRACTICE FOR SALE: Physician's widow wishes to sell well-equipped, spacious, beautifully furnished office and parking lot, Boca Ciega Bay, 5 minutes from Palm hospital, excellent general and internal medicine practice. 290-75th Ave., St. Petersburg Beach, Fla. 33702. Phone 361-2921.

Florida Medical Association

735 Riverside Ave., P. O. Box 2411

Jacksonville, Florida 32203

Officers

W. Dean Steward, M.D., President	Orlando
Jack Q. Cleveland, M.D., President-Elect	Coral Gables
Irving E. Hall Jr., M.D., Vice President	Bradenton
James T. Cook, M.D., Speaker of the House	Marianna
Charles K. Donegan, M.D., Vice Speaker	St. Petersburg
Floyd K. Hurt, M.D., Secretary-Treasurer	Jacksonville
George S. Palmer, M.D., Immediate Past President	Tallahassee
W. Harold Parham, Executive Director	Jacksonville

Councils

Jesse W. Castleberry, M.D., Chairman, Council on Allied Professions and Vocations	Orlando
John J. Cheleden, M.D., Chairman, Judicial Council	Daytona Beach
Jere W. Annis, M.D., Chairman, Council on Legislation and Public Agencies	Lakeland
Jack A. MaCris, M.D., Chairman, Council on Medical Economics	St. Petersburg
James M. Ingram, M.D., Chairman, Council on Medical Services	Tampa
Richard C. Dever, M.D., Chairman, Council on Scientific Activities	Miami
John D. Milton, M.D., Chairman, Council on Special Activities	Coral Gables
Sanford A. Mullen, M.D., Chairman, Council on Specialty Medicine	Jacksonville
Mason Romaine III, M.D., Chairman, Council on Voluntary Health Agencies	Jacksonville

Information for Authors

Manuscripts submitted for publication in the Journal of the Florida Medical Association should be double or triple spaced on white bond, including title page, illustration legends, charts and graphs, table headings, footnotes and bibliography.

Submit original manuscript and two copies. Copying by electrostatic dry process (not wet process) is preferred to tissue copies. Retain one additional copy in your office for proofreading. All material is submitted with the understanding it is subject to editing.

Photographs should be submitted as 5x7 glossy prints, untrimmed and unmounted; number each photograph *lightly* on the back with pencil and indicate top. Charts, graphs and medical illustrations should be submitted as india ink drawings on white gloss paper; remember to make details large enough to allow for photographic reduction. It is a policy of the Journal that authors pay for any cuts made to illustrate their papers.

Titles should be short, specific and clear. Omit phrases such as "The Use of," "Observations on." If paper was presented at a meeting, indicate name of organization, city, month, day and year.

Only original papers not previously published are accepted for publication. Manuscripts submitted for publication are subject to review and approval by the Journal Publications Committee. Except by invitation, only papers from members of the Florida Medical Association are considered for publication.

References should be typewritten, double or triple spaced, beginning on a new sheet of paper entitled "References." Number references in the text in order of citation and prepare bibliography in the same order. Bibliographies should conform to the style of the Index Medicus. The Journal prints only bibliographies of eight references or less; bibliographies of more than eight references are referred to at the end of the paper with the statement "References are available from the author upon request."

All manuscript pages should be numbered consecutively. Within the manuscript, numbers one to nine should be spelled out except when used for units of measurement; for numbers above nine, numerals should be used. Dorland's Medical Dictionary and Webster's International Dictionary may be used as standard references. Scientific names for drugs should be used when possible. Copyright or trade names of drugs should be capitalized.

Index to Advertisers

Abbott Laboratories
Enduron 1002a
Enduronyl 1002a
Erythrocin Sulfas 990-992
Eutonyl 1002a
Eutron 1002a

Ames Company, Inc.
Dextrostix 994

Anderson Surgical Supply Co. 1002

Appalachian Hall 1017

Associated Management 992

Ballast Point Manor 1010

Bristol Laboratories
Prostaphlin 1008-1009
Tetrex F. 996

Burroughs-Wellcome Co.
Neosporin 950a

Campbell Soups 442a

Coca-Cola 1017

Conal Pharmaceuticals
Urised 953

Convention Press 981

Dorsey Laboratories
Triaminic 986a, 1007
Tussagesic 978

Duvall Home 986

Gebauer Chemical Co.
Ethyl Chloride 1006a

Geigy Pharmaceuticals
Butazolidin 1004-1005
Preludin 978a

Glenbrook Laboratories
Bayer Aspirin 1003

Highland Hospital, Inc. 1014

Hill Crest Hospital 1019

Hoechst Pharmaceutical
Lasix 943-946

Hynson, Westcott & Dunning, Inc.
BSP Disposable 935

Lakeside Laboratories, Inc.
Cantil 1011

Lederle Laboratories
Declomycin 946a
Stresscaps 936

Eli Lilly & Co.
Ilosone 978a
Tes-Tape 954
Tuinal 1006a
V-Cillin K 442a

Medical Supply Co. 989

National Drug Co.
Quinamm 1014a

Parke-Davis & Co.
Dilantin Second Cover

Pediatric Care Center 1014

Pitman-Moore Co.
Novahistine LP 1012-1013

P. L. Dodge Memorial Hospital 1016

PM of Florida 980

William P. Poythress & Co.
Mudrane 1014a
Solfoton 981
Synirin 980
Trocinate 986

Professional Billing Corp. 987

A. H. Robins, Inc.
Dimetapp 978a
Donnagel 994a
Phenaphen 950a
Robitussin 994a, 995

Roche Laboratories
Valium Back Cover

Wm. H. Rorer, Inc.
Parepectolin 952

Rystan Company
Chloresium 989

Sandoz
Mellaril 1014a

G. D. Searle Co.
Lomotil 978a

Smith, Kline & French
Ornade 1015

Stamas Boats 1006a

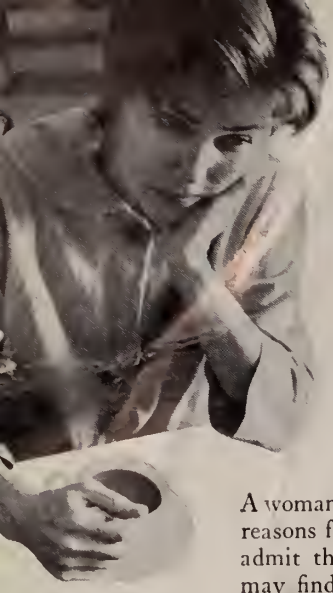
Stuart Co.
Mylanta 993

Surgical Supply Co. 1016

Syntex Laboratories
Norinyl 947-950
Synalar 982-985

Tucker Hospital, Inc. 1016

Winthrop Laboratories
Talwin 1010a



Tears without grief

LIBRARY
OCT - 5 1967
OF MEDICINE

Crying Spells–psychic tension with depressive symptoms?

"I don't know what's the matter with me lately...I cry and I cry... and I really don't know why I do."

A woman often is not conscious of the real reasons for her crying spells or refuses to admit them to herself. On probing, you may find that frequent weeping, like insomnia or neurotic fatigue, often is an expression of psychic tension. She needs sympathy and reassurance, and perhaps a calming agent to help her over her crisis. Consider prescribing Valium (diazepam) for her. It usually reestablishes calmness promptly. Crying spells and other secondary depressive symptoms normally subside as the tension is relieved. Your patient then can cope more easily with stresses to which she is subjected. Valium (diazepam) is generally well tolerated, and on proper mainteenance dosage usually does not impair mental acuity or ability to function. If side effects such as ataxia and drowsiness occur, they usually disappear with dosage adjustment.

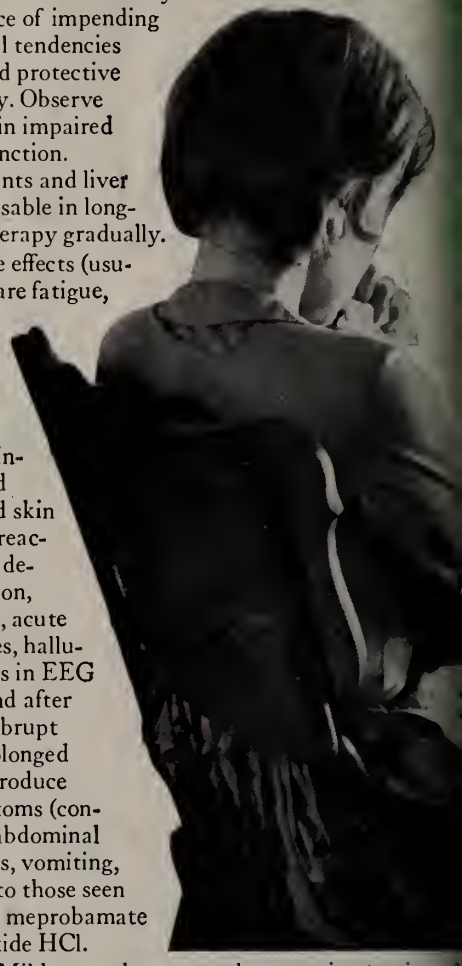


Before prescribing, please consult complete product information, a summary of which follows:

Contraindications: Infants, patients with history of convulsive disorders, glaucoma or known hypersensitivity to drug.

Warning: Not of value in the treatment of psychotic patients, and should not be employed in lieu of appropriate treatment.

Precautions: Limit dosage to smallest effective amount in elderly or debilitated patients (not more than 1 mg, one or two times daily initially) to preclude ataxia or oversedation, increasing gradually as needed or tolerated. As is true of all CNS-acting drugs, until correct maintenance dosage is established, advise patients against possibly hazardous procedures requiring complete mental alertness or physical coordination. Driving during therapy not recommended. In general, concurrent use with other psychotropic agents is not recommended. If such combination therapy is used, carefully consider individual pharmacologic effects–particularly with known compounds which may potentiate action of Valium (diazepam), such as phenothiazines, barbiturates MAO inhibitors and other antidepressants. Advise patients against simultaneous ingestion of alcohol or other CNS depressants. Safe use in pregnancy not established. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Observe usual precautions in impaired renal or hepatic function. Periodic blood counts and liver function tests advisable in long-term use. Cease therapy gradually.



Side Effects: Side effects (usually dose-related) are fatigue, drowsiness and ataxia. Also reported: mild nausea, dizziness, blurred vision, diplopia, headache, incontinence, slurred speech, tremor and skin rash; paradoxical reactions (excitement, depression, stimulation, sleep disturbances, acute hyperexcited states, hallucinations); changes in EEG patterns during and after drug treatment. Abrupt cessation after prolonged overdosage may produce withdrawal symptoms (convulsions, tremor, abdominal and muscle cramps, vomiting, sweating) similar to those seen with barbiturates, meprobamate and chlordiazepoxide HCl.

Dosage: *Adults:* Mild to moderate psychoneurotic reactions, 2 to 5 mg b.i.d. or t.i.d.; severe psychoneurotic reactions, 5 to 10 mg t.i.d. or q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; muscle spasm with cerebral palsy or athetosis, 2 to 10 mg t.i.d. or q.i.d. *Geriatric patients:* 1 or 2 mg/day initially, increase gradually as needed and tolerated. (See Precautions.)

Supplied: Valium® (diazepam) Tablets, 2 mg, 5 mg and 10 mg; bottles of 50 and 500.

Roche Laboratories, Division of Hoffmann-La Roche Inc.
Nutley, N.J. 07110

Library
New York Academy of Medicine
2 East 103rd St
New York N Y J 12-67
10029

Valium® (diazepam) Roche®

useful for the relief of psychic tension with associated depressive symptoms

NOVEMBER, 1967
Volume 54
Number 11

The JOURNAL of the Florida Medical Association

In This Issue

Amebiasis
Cleft Palate
Heart Surgery
Creeping Eruption
Inpatients' Attitudes

OFFICIAL PUBLICATION OF THE FLORIDA MEDICAL ASSOCIATION

Scientific Papers and Exhibits Sought for Annual Meeting
See Page 1050

Dilantin®
(diphenylhydantoin)

PARKE-DAVIS

In untold thousands of epileptic patients... Dilantin has been, and continues to be, the bedrock of therapy.

DILANTIN is useful in the treatment of grand mal epilepsy and certain other convulsive states. Its use will prevent or greatly reduce the incidence and severity of convulsive seizures in a substantial percentage of epileptic patients, without the hypnotic and narcotizing effects of many anticonvulsant drugs.
PRECAUTIONS: Periodic examination of the blood is advisable. Nystagmus in combination with diplopia and ataxia indicates dosage should be reduced. The possibility of toxic effects during pregnancy has not been explored. ADVERSE REACTIONS: Allergic phenomena such as polyarthropathy, fever, skin eruptions, and acute generalized morbilliform eruptions with or without fever. Rarely, dermatitis goes on to exfoliation with hepatitis, and further dosage is contraindicated. Gingival hypertrophy, hirsutism, and excessive motor activity are occasionally encountered. During initial treatment, side effects may include gastric distress, nausea, weight loss, nervousness, sleeplessness, feeling of unsteadiness. Macrocytosis, megaloblastic anemia, leukopenia, granulocytopenia, thrombocytopenia, pancytopenia, agranulocytosis, and aplastic anemia have been reported. Nystagmus, lymphadenopathy, lupus erythematosus, erythema multiforme (Stevens-Johnson syndrome), and a syndrome resembling infectious mononucleosis with jaundice have occurred.
DILANTIN is supplied in several forms including Kapseals® containing 0.1 Gm. and 0.03 Gm. diphenylhydantoin sodium.
Parke, Davis & Company, Detroit, Michigan 48232

The color combinations of the banded capsules are Parke-Davis trademarks. The orange-banded white capsule identifies Parke-Davis 0.1 Gm. diphenylhydantoin sodium; the pink-banded white capsule 0.03 Gm. diphenylhydantoin sodium.

PARKE-DAVIS 015R67





■ to help restore and stabilize the intestinal flora

■ for fever blisters and canker sores of herpetic origin

LACTINEX contains both *Lactobacillus acidophilus* and *L. bulgaricus* in a standardized viable culture, with the naturally occurring metabolic products produced by these organisms.

First introduced to help restore the flora of the intestinal tract in infants and adults,[1, 2, 3, 4] LACTINEX has also been shown to be useful in the treatment of fever blisters and canker sores of herpetic origin.[5, 6, 7, 8]

No untoward side effects have been reported to date.

Literature on indications and dosage available on request.

References:

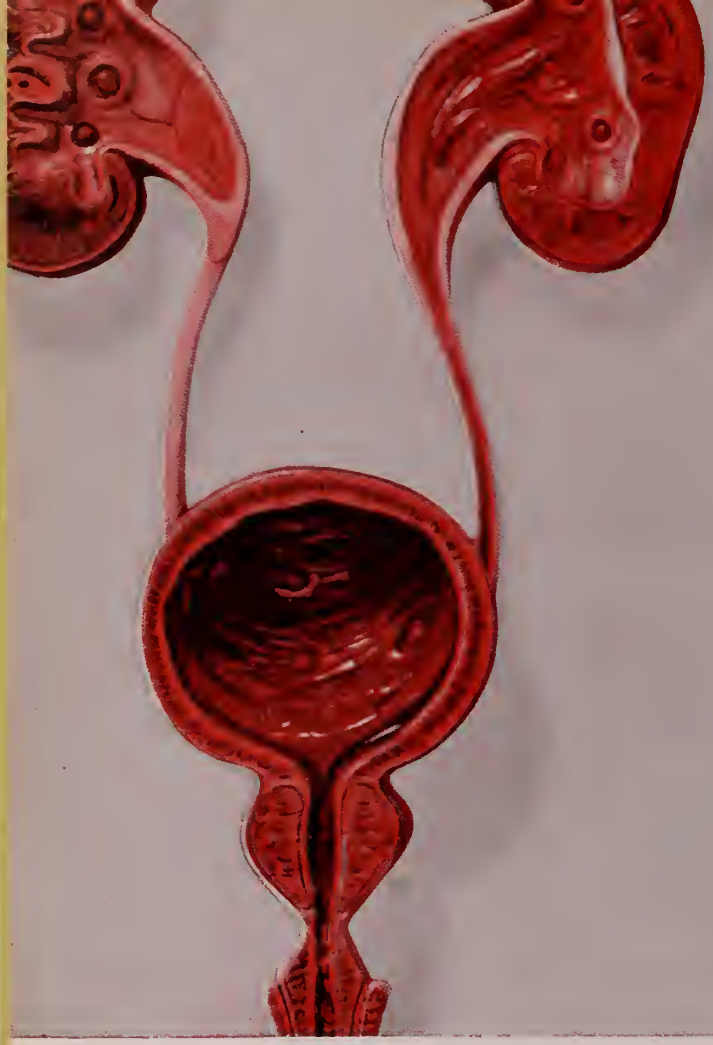
(1) Siver, R. H.: CMD, *21*:109, September 1954. (2) Frykman, H. H.: Minn. Med., *38*:19-27, January 1955. (3) McGivney, J.: Tex. State Jour. Med., *51*:16-18, January 1955. (4) Quehl, T. M.: Jour. of Florida Acad. Gen. Prac., *15*:15-16, October 1965. (5) Weekes, D. J.: N.Y. State Jour. Med., *58*:2672-2673, August 1958. (6) Weekes, D. J.: EENT Digest, *25*:47-59, December 1963. (7) Abbott, P. L.: Jour. Oral Surg., Anes., & Hosp. Dental Serv., 310-312, July 1961. (8) Rapoport, L. and Levine, W. I.: Oral Surg., Oral Med. & Oral Path., *20*:591-593, November 1965.

HYNSON, WESTCOTT & DUNNING, INC.

BALTIMORE, MARYLAND 21201

(LX04)

LX
LX
LX



Diagnosis:

cystitis?
pyelonephritis?
pyelitis?
urethritis?
prostatitis?

in any case,
usually gram-negative*

Therapy:

two 500 mg. Caplets® q.i.d
(initial adult dose)

Indications: Urinary tract infections caused by gram-negative and some gram-positive organisms.

Side effects: Mainly mild, transient gastrointestinal disturbances; in occasional instances, drowsiness, fatigue, pruritus, rash, urticaria, mild eosinophilia, reversible subjective visual disturbances (overbrightness of lights, change in visual color perception, difficulty in focusing, decrease in visual acuity and double vision), and reversible photosensitivity reactions. Marked overdosage, coupled with certain predisposing factors, has produced brief convulsions in a few patients.

Precautions: As with all new drugs, blood and liver function tests are advisable during prolonged treatment. **Pending further experience, like most chemotherapeutic agents, this drug should not be given in the first trimester of pregnancy. It must be used cautiously in patients with liver disease or severe impairment of kidney function.** Because photosensitivity reactions have occurred in a small number of cases, patients should be cautioned to avoid unnecessary exposure to direct sunlight while receiving NegGram, and if a reaction occurs, therapy should be discontinued. The dosage recommended for adults and children should not arbitrarily be doubled unless under the careful supervision of a physician. Bacterial resistance may develop.

When testing the urine for glucose in patients receiving NegGram, Clinistix® Reagent Strips or Tes-Tape® should be used since other reagents give a false-positive reaction.

Dosage: Adults: Four Gm. daily by mouth (2 Caplets® of 500 mg. four times daily) for one to two weeks. Thereafter, if prolonged treatment is indicated, the dosage may be reduced to two Gm. daily. Children may be given approximately *25 mg. per pound* of body weight per day, administered in divided doses. The dosage recommended above for adults and children should not arbitrarily be doubled unless under the careful supervision of a physician. Until further experience is gained, infants under 1 month should not be treated with the drug.

How supplied: Buff-colored, scored Caplets® of **500 mg. for adults,** conveniently available in bottles of 56 (sufficient for one full week of therapy) and in bottles of 1000. **250 mg. for children,** available in bottles of 56 and 1000.

References: (1) Based on 23 clinical papers, 1512 cases. Bibliography on request. (2) Bush, I. M., Orkin, L. A., and Winter, J. W., in Sylvester, J. C.: Antimicrobial Agents and Chemotherapy—1964, Ann Arbor, American Society for Microbiology, 1965, p. 722.

Winthrop

Winthrop Laboratories, New York, N. Y. 10016

NegGram

Brand of

nalidixic acid

a specific anti-gram-negative

eradicates most urinary tract infections...

- Low incidence of untoward effects; no fungal overgrowth, crystalluria, ototoxic or nephrotoxic effects have been observed.
- "Excellent" or "good" response reported *in more than 2 out of 3* patients with either chronic or acute gram-negative infections.[1]

*As many as 9 out of 10 urinary tract infections are now caused by gram-negative organisms: E. coli, Klebsiella, Aerobacter, Proteus, Paracolon or Pseudomonas[2]... However, infections of the urethra and prostate caused by non-gonococcal gram-negative organisms are believed to be less prevalent.

The JOURNAL
of the Florida Medical Association

Volume 54, Number 11, November 1967

THAD MOSELEY, M.D.
Editor

Assistant Editors

JOHN M. PACKARD, M.D.
OSCAR W. FREEMAN, M.D.

Assistant Editor from the Board of Governors
JACK Q. CLEVELAND, M.D.

W. HAROLD PARHAM
Managing Editor

EUGENE L. NIXON
Associate Managing Editor

LOUISE RADER
Assistant Managing Editor

EDITH B. HILL
Editorial Consultant

ublished monthly at Jacksonville, orida. Price $7.00 a year, single num- r, 70 cents. Address Journal of orida Medical Association, P.O. Box 11, 735 Riverside Ave., Jacksonville, a. 32203. Telephone (904) 356-1571. Ac- pted for mailing at special rate of stage provided for in Section 1103, ct of Congress of October 3, 1917; uthorized October 16, 1918. Entered second class matter under Act of ngress of March 3, 1879, at the post fice at Jacksonville, Florida, October , 1924. Available on microfilm begin- ng with the 1967 volume. Address quiries to University Microfilms, 300 orth Zeeb Road, Ann Arbor, Michi- an 48106.

THIS ISSUE

Scientific Section

Otological Manifestations in Cleft Palate, Eugene F. Northcott, M.D. and Hueston C. King, M.D. 1047
Early Care of Heart Surgery Patient After Operation, Prentiss E. Smith, M.D., Kazi Mobin-Uddin, M.D., Carlos R. Lombardo, M.D. and James R. Jude, M.D. 1051
Medical Inpatients' Attitudes Toward Physicians and Hospitalization, John J. Schwab, M. D., Sidney B. Denman, Ph.D., Joseph F. Aponte, M.A., and Mary Helen Berkshire, B.A. 1056
Treatment of Creeping Eruption With Thiabendazole, Perry A. Sperber, M.D. 1059
Amebiasis in South Florida, Elizabeth Barrett-Connor, M.D. and J. Walter Beck, Ph.D. 1062

Editorials

Early Care of the Heart Surgery Patient After Operation, Thomas D. Bartley, M.D. 1070
Creeping Eruption (Larva Migrans), Joseph A. Farrington, M.D. 1070
Report of Ad Hoc Committee on Resolution 67-22 Blue Cross-Blue Shield, Warren W. Quillian, M.D. 1071

Departments

President's Page 1031
News 1035
Public Health Topics 1038
Government News 1074
Association News 1077
50 Years Ago in the Journal 1087
The Medical Detective 1093
Letter to the Editor 1099
Deaths 1106
Classified 1108

Miscellaneous

National and Regional Meetings in Florida 1100
Meetings 1103
Florida Medical Association Officers and Council Chairmen 1110
Information for Authors 1110
Index to Advertisers 1111

Owned and published by the Florida Medical Association, Inc. The Journal is not responsible for the opinions and statements of its contributors.

Don't let monilia cut broad-spectrum therapy short...

start with Tetrex-F®

tetracycline phosphate complex-nystatin

Use of broad-spectrum antibiotics can cause fungal overgrowth in the alimentary tract... and give rise to symptoms so troublesome that therapy must be prematurely stopped. Tetrex-F (tetracycline phosphate complex-nystatin) helps you circumvent this problem.

The nystatin can prevent overgrowth of monilia; the phosphate complex delivers tetracycline to the blood rapidly. Side effects are infrequent.

High-Risk Patients

Tetrex-F (tetracycline phosphate complex-nystatin) is especially useful in patients most susceptible to fungal overgrowth during tetracycline therapy: (1) the elderly or debilitated, (2) young children, (3) the diabetic, (4) those on long-term tetracycline therapy, (5) those on steroid therapy, (6) those who have had moniliasis before, and (7) pregnant patients with a history of monilial vaginitis.

When you start with economical Tetrex-F (tetracycline phosphate complex-nystatin), you can complete the full course of broad-spectrum therapy with less chance of losing control elsewhere. A good start for a healthy finish.

PRESCRIBING INFORMATION. For complete information consult Official Package Circular. *Indications:* Infections of respiratory, gastrointestinal and genitourinary tracts and skin and soft tissues due to tetracycline-sensitive organisms, in patients with increased susceptibility to monilial infections. *Contraindications:* The drug is contraindicated in patients hypersensitive to its components. *Warnings:* Photodynamic reactions have been produced by tetracyclines. Natural and artificial sunlight should be avoided during therapy. Stop treatment if skin discomfort occurs. With renal impairment, systemic accumulation and hepatotoxicity may occur. In this situation, lower doses should be used. Tooth staining and enamel hypoplasia may be induced during tooth development (last trimester of pregnancy, neonatal period and childhood). *Precautions:* Bacterial superinfections may occur. Infants may develop increased intracranial pressure with bulging fontanels. In gonorrheal therapy, serologic tests for syphilis should be conducted initially and monthly for 3 months. *Adverse Reactions:* Glossitis, stomatitis, nausea, diarrhea, flatulence, proctitis, vaginitis, dermatitis, and allergic reactions may occur. *Usual Adult Dosage:* 1 capsule q.i.d. Continue for 10 days in Beta-hemolytic streptococcal infections. Administer one hour before or two hours after meals. *Supplied:* Capsules, bottles of 16 and 100. Each capsule contains tetracycline phosphate complex equivalent to 250 mg. tetracycline HCl activity and 250,000 units of nystatin. For Oral Suspension, 125 mg. tetracycline and 125,000 u. nystatin/5 ml., 60 ml. bottles.

BRISTOL

BRISTOL LABORATORIES
Division of Bristol-Myers Company
Syracuse, New York 13201



President's Page

Due to the timeliness of reacquainting the membership with the FMA Investment Plan, Dr. Floyd K. Hurt, chairman of the FMA Investment Plan Committee, has graciously accepted my invitation to utilize the President's Page to inform the membership regarding this excellent opportunity for FMA members to provide themselves financial security, both for the present and for the retirement years to come. Further information regarding the FMA Investment Plan may be found under the Association News heading of this Journal.

W. Dean Steward, M.D.
President

The Doctor in His House

As doctors, we frequently advise that peace of mind can do wonders for our patients. Yet how many of us have set up a definite plan designed to accumulate capital and provide financial peace of mind for ourselves? No one in the Florida Medical Association actually plans to be poor upon his retirement—but how many of us make plans not to be? Yet we all know that society in this country makes no such provisions for the doctor in his retirement years as it does for members of so many other groups. He is strictly on his own.

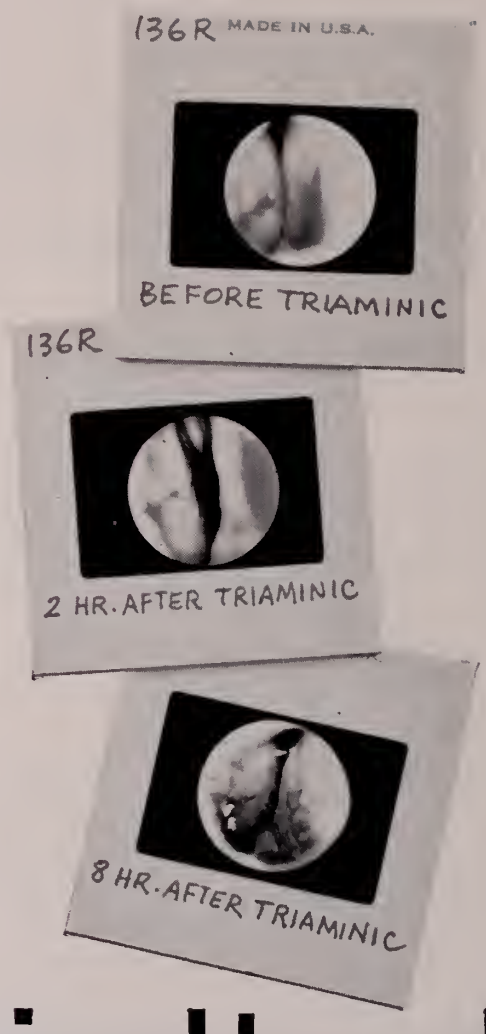
Thus far there are no medical schools which include even an elementary course in investment management and financial planning. When a doctor at long last hangs out his shingle, he is so thoroughly engrossed in his profession that there is little time for personal financial planning beyond the necessary routine of bookkeeping, bill collecting and banking; however, he must and should set up his own savings and investment program. In his productive years, his income is usually such that with intelligent financial and investment planning plus sound counsel, the doctor can achieve peace of mind in his active years and a rewarding retirement for his family and himself in later years.

Since by professional training, experience and temperament the doctor is usually less well equipped and has less time to cope with this kind of problem than the average nonprofessional or businessman, your Investment Plan Committee has spent a good deal of time in developing a practical and attractive retirement-investment program for our members. The FMA Investment Plan now combines the talents and services of two nationally known organizations, each outstanding in its field. Loomis, Sayles & Company, one of the country's largest and most experienced investment counsel firms, provides the investment portion of the Plan. Pan American Life Insurance Company of New Orleans, one of the South's largest insurance companies, offers the Plan's annuity feature. Your Committee enthusiastically recommends, and the officers of your Association endorse, the Plan for your active consideration. You can choose either an aggressive or conservative investment for your "grow power" and combine it with an annuity that provides guaranteed dollar benefits.

You can now set up a Keogh (H.R. 10) plan, or not, whichever you wish, and take advantage of the recently increased tax benefits possible under the Keogh Act. The operating costs are at an absolute minimum—this was something your Committee insisted upon. Personal service and contact on a continuing basis are provided by specially trained Plan Representatives throughout the state. You do not have to put together your own plan through the mails in a program offered from afar. This Plan is especially tailored for physicians. It concerns you as intelligent persons—it concerns your families.

Floyd K. Hurt, M.D., Chairman
FMA Investment Plan Committee

From a continuing study on nasal congestion . . .



timed to work while your patient does

A study being conducted by the Department of Otolaryngology, Greater Baltimore Medical Center is stockpiling evidence that points to the fast action and prolonged relief effected by Triaminic in the treatment of nasal congestion.

Begun in March 1966, the study to date has encompassed 85 patients with common nasal disorders—and measured their response to recommended doses of Triaminic tablets.

Timed to release its oral nasal decongestant and two antihistamines within 8 hours, Triaminic was found to effect partial or complete relief in better than 82% of the subjects treated. Clearing nasal obstruction. Reducing turbinate swelling. Making breathing easier.

It's a comforting thing to know that Triaminic *really* works.

Triaminic® *timed-release tablets*

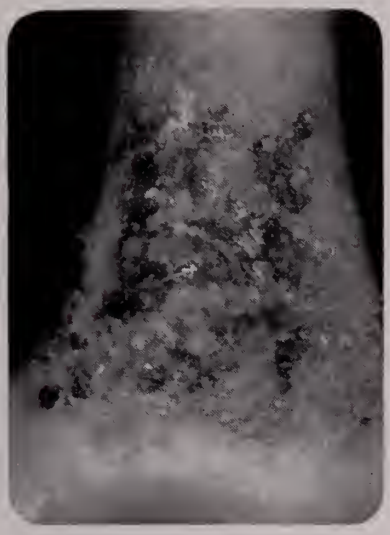
Each timed-release tablet contains:

Phenylpropanolamine hydrochloride 50mg. Pyrilamine maleate..... 25mg. Pheniramine maleate..... 25mg.

Side effects: Occasional drowsiness, blurred vision, cardiac palpitations, flushing, dizziness, nervousness or gastrointestinal upsets. Precautions: The patient should be advised not to drive a car or operate dangerous machinery if drowsiness occurs. Use with caution in patients with hypertension, heart disease, diabetes or thyrotoxicosis.

DORSEY LABORATORIES • *a division of The Wander Company* • **LINCOLN, NEBRASKA** 68501

Eczema of many years... controlled in two weeks



Before treatment



After treatment — with ARISTOCORT Topical Ointment 0.1% for two weeks

ARISTOCORT® Triamcinolone Acetonide Topicals have proved exceptionally effective in the control of various forms of eczema: allergic, atopic, nummular, psoriatic, and mycotic.

In most cases responsive to topical ARISTOCORT, the 0.1% concentration is sufficiently potent. The 0.5% concentration provides enhanced topical activity for patients requiring additional potency for proper relief.

Administration and Dosage: Apply sparingly to the affected area 3 or 4 times daily. Some cases of psoriasis may be more effectively treated if the 0.1% Cream or Ointment is applied under an occlusive dressing.

Contraindications: Tuberculosis of the skin, herpes simplex, chicken pox and vaccinia.

Precautions and Side Effects: Do not use in the eyes or in the ear (if drum is perforated). A few individuals react unfavorably under certain conditions. If side effects are encountered, the drug should be discontinued and appropriate measures taken. Use on infected areas should be attended with caution and observation, bearing in mind the potential spreading of infection and the advisability of discontinuing therapy and/or initiating antibacterial measures. Generalized dermatological conditions may require systemic corticosteroid therapy. Steroid therapy, although responsible for remissions of dermatoses, especially of allergic origin cannot be expected to prevent recurrence. The use over extensive body areas, with or without occlusive nonpermeable dressings, may result in systemic absorption. Appropriate precautions should be taken. When occlusive nonpermeable dressings are used, miliaria, folliculitis and pyodermas will sometimes develop. Localized atrophy and striae have been reported with the use of steroids by the occlusive technique. When occlusive nonpermeable dressings are used, the physician should be aware of the hazards of suffocation and flammability. The safety of use on pregnant patients has not been firmly established. Thus, do not use in large amounts or for long periods of time on pregnant patients.

Available in 5 Gm. and 15 Gm. tubes and ½ lb. jars.

PHOTOGRAPHS COURTESY OF M. M. NIERMAN, M.D.

Aristocort® Topical Ointment 0.1% and Cream 0.1%, 0.5%
Triamcinolone Acetonide
Also available in foam form.

Lederle LEDERLE LABORATORIES, A Division of American Cyanamid Company, Pearl River, New York

406-6

DEPRESSION



NORPRAMIN®
(desipramine hydrochloride)

ANTIDEPRESSANT FOR RAPID IMPROVEMENT

At the recommended dosage level —initially, 150 mg. per day— gratifying remission of the signs and symptoms of depression typically begins in 2-5 days. Its specificity for depression, rapidity of action and usually mild side effects are significant reasons for prescribing NORPRAMIN (desipramine hydrochloride) in depression of any type . . . any degree of severity.

A few patients, sensitive to central nervous system stimulants may become restless as depression is lifted—in such cases dosage may be reduced or a tranquilizer added.

IN BRIEF:

INDICATIONS: In depression of any kind —neurotic and psychotic depressive reactions; manic-depressive or involutional psychotic reactions.

CONTRAINDICATIONS: Glaucoma, urethral or ureteral spasm, recent myocardial infarction, severe coronary heart disease, epilepsy. Should not be given within two weeks of treatment with a monoamine oxidase inhibitor.

RELATIVE CONTRAINDICATIONS: (1) Patients with a history of paroxysmal tachycardia. (2) Patients receiving concomitant therapy with thyroid, anticholinergics or sympathomimetics may experience potentiation of effects of these drugs. (3) Safety in pregnancy has not been established.

PRECAUTIONS: (1) Outpatient use of desipramine hydrochloride should not be substituted for hospitalization when risk of suicide or homicide is considered grave. (2) If serious adverse effects occur, reduce dosage or alter treatment. (3) In patients with manic-depressive illness a hypomanic state may be induced. (4) Discontinue drug as soon as possible prior to elective surgery.

ADVERSE EFFECTS: Side effects, usually mild, may include: dry mouth, constipation, dizziness, palpitation, delayed urination, "bad taste," sensory illusion, tinnitus, anxiety, agitation and stimulation, insomnia, sweating, drowsiness, headache, orthostatic hypotension, flushing, nausea, cramps, weakness, blurred vision and mydriasis, rash, tremor, allergy, agranulocytosis, altered liver function, ataxia, and extrapyramidal signs.

DOSAGE: Optimal results are obtained at a dosage of 50 mg., t.i.d. (150 mg./day). **SUPPLIED:** NORPRAMIN (desipramine hydrochloride) tablets of 25 mg.; bottles of 50, 500 and 1000; and tablets of 50 mg., in bottles of 30, 250 and 1000.

LAKESIDE

LAKESIDE LABORATORIES, INC., Milwaukee, Wisconsin 53201

The AMBAR SCRAPBOOK of

Obesity Oddities

FACT & LEGEND

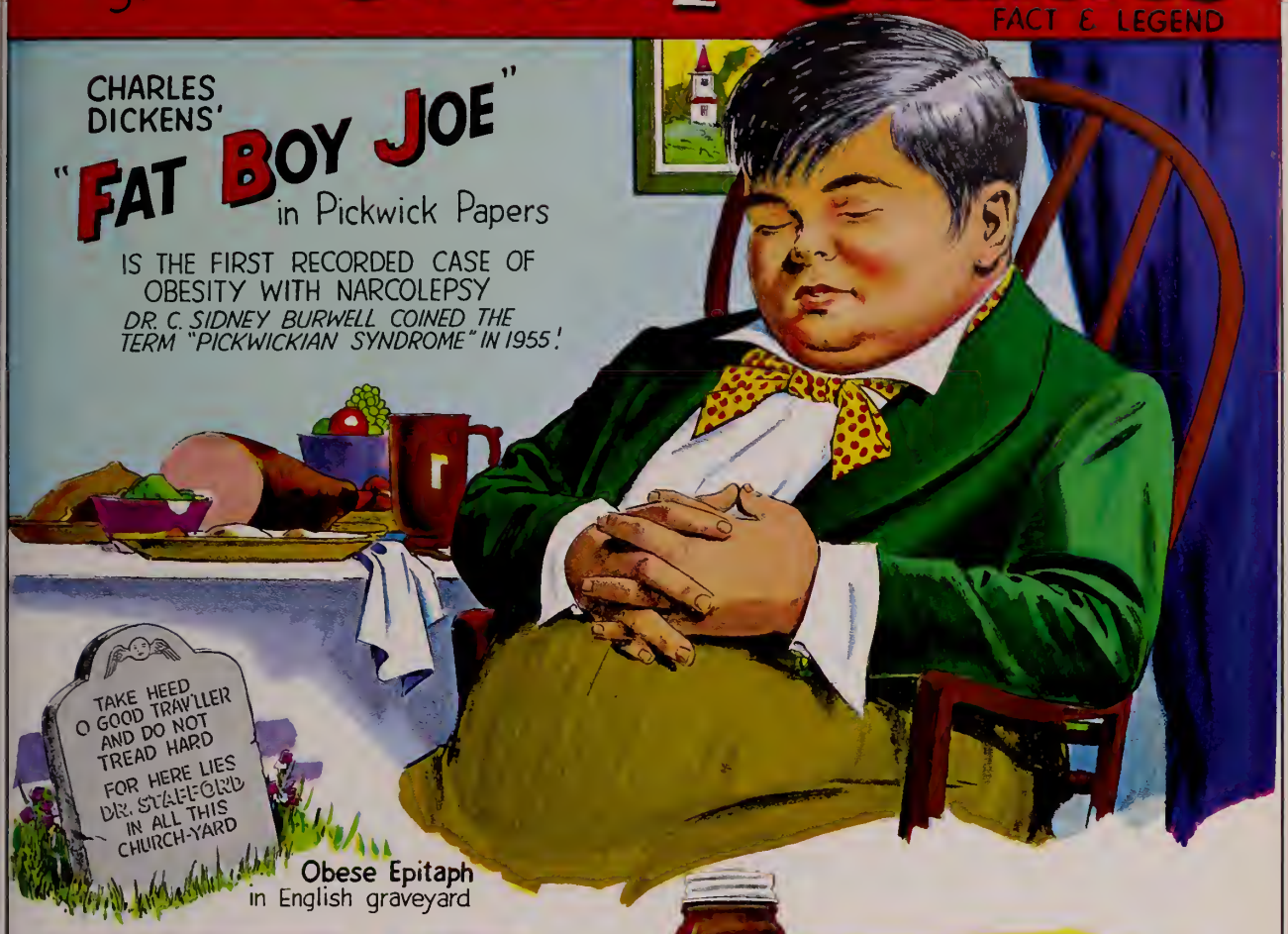
CHARLES DICKENS'

"FAT BOY JOE"

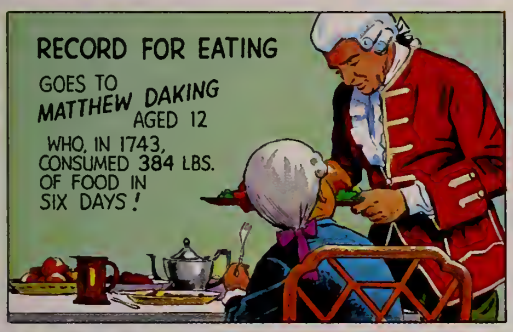
in Pickwick Papers

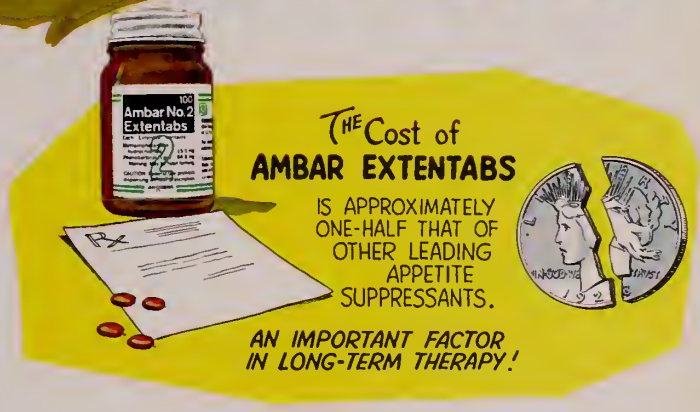
IS THE FIRST RECORDED CASE OF OBESITY WITH NARCOLEPSY

DR. C. SIDNEY BURWELL COINED THE TERM "PICKWICKIAN SYNDROME" IN 1955!



Obese Epitaph in English graveyard





CONTROL FOOD AND MOOD ALL DAY LONG WITH A SINGLE MORNING DOSE

AMBAR #2 EXTENTABS®

methamphetamine HCl 15 mg., phenobarbital 64.8 mg. (1 gr.) (Warning: may be habit forming).

One Ambar Extentab before breakfast can help control most patients' appetite for up to 12 hours. Methamphetamine, the appetite suppressant, gently elevates mood and helps overcome dieting frustrations. Phenobarbital, the sedative in Ambar, controls irritability and anxiety... helps maintain a state of mental calm and equanimity. Both work together to ease the tensions that erode the willpower during periods of dieting.

Also available: Ambar #1 Extentabs®—methamphetamine hydrochloride 10 mg., phenobarbital 64.8 mg. (1 gr.) (Warning: may be habit forming).

BRIEF SUMMARY/**Indications:** Ambar suppresses appetite and helps offset emotional reactions to dieting. **Contraindications:** Hypersensitivity to barbiturates or sympathomimetics; patients with advanced renal or hepatic disease. **Precautions:** Administer with caution in the presence of cardiovascular disease or hypertension. **Side Effects:** Nervousness or excitement occasionally noted, but usually infrequent at recommended dosages. Slight drowsiness has been reported rarely. See package insert for further details.

A. H. ROBINS COMPANY, RICHMOND, VA. 23220

A·H·ROBINS



Help clear up that miserable stuffed-up feeling with Dimetapp. Each hard-working Extentab brings welcome relief from the stuffiness, drip and congestion of upper respiratory conditions for up to 10-12 hours. Yet, patients seldom experience drowsiness or overstimulation. The key to success is the Dimetapp formula: Dimetane (brompheniramine maleate)—along with phenylephrine and phenylpropanolamine, two time-tested decongestants. They get the job done . . . in a hurry.

Indications: Dimetapp is indicated for symptomatic relief of the allergic manifestations of respiratory illnesses, such as the common cold and bronchial asthma, seasonal allergies, sinusitis, rhinitis, conjunctivitis, and otitis. *Contraindications:* Hypersensitivity to antihistamines. Not recommended for use during pregnancy. *Precautions:* Until patient's response has been determined, he should be cautioned against engaging in operations requiring alertness. Administer with care to patients with cardiac or peripheral vascular diseases or hypertension. *Side Effects:* Hypersensitivity reactions including skin rashes, urticaria, hypotension and thrombocytopenia, have been reported on rare occasions. Drowsiness, lassitude, nausea, giddiness, dryness of the mouth, mydriasis, increased irritability or excitement may be encountered. *Dosage:* 1 Extentab morning and evening. *Supplied:* Bottles of 100 and 500.

A.H. ROBINS COMPANY
RICHMOND, VA. 23220
A·H·ROBINS

in sinusitis, colds, U.R.I.
Dimetapp® Extentabs®
(Dimetane® [brompheniramine maleate], 12 mg.; phenylephrine HCl, 15 mg.; phenylpropanolamine HCl, 15 mg.)
up to 10-12 hours clear breathing on one tablet



NEWS

UM Scientist Calls for Pesticide Study

A University of Miami medical scientist has called for an intensified study of the effects of organochlorine pesticides—such as DDT—on human metabolism.

William B. Deichmann, Ph.D., speaking at a meeting sponsored by the American Medical Association in Atlanta. Sept. 25, said that preliminary evidence gathered in the medical school's department of pharmacology indicated that "the household use of spray (inhalation) pesticides is of greater significance than is generally recognized."

People who use a lot of pesticides in their homes have a correspondingly high concentration of residual pesticides in their bodies, according to studies made by Dr. Deichmann, professor and chairman of the department, and his colleagues. Hitherto, the traces of organochlorine pesticides found in fatty tissues were thought to come primarily from eating foods.

The finding is significant, said Dr. Deichmann, since it is known that the presence of one chemical in the body may produce changes in metabolism which may influence the effects of other drugs or chemicals. This response may take place in the microsomal enzymes—the body's own mechanism for breaking down most chemicals and drugs.

"An induced modified liver microsomal enzyme activity can be responsible for an increased or a decreased potency of certain pesticides or drugs absorbed subsequently. The same mechanism appears to be capable of modifying the path of metabolism or the type of metabolites formed. DDT and the long-acting barbiturates deserve more intensive evaluation in this respect."

Overseas Need For Medical Journals

The World Medical Association and the American Medical Association are asking physicians of the U.S.A. to send their medical journals, after they have read them, to colleagues overseas who wish to have access to recent medical literature but, either because of currency regulations or actual cost, cannot themselves subscribe to medical periodicals.

Physicians wishing to participate may send their name, address and titles of journals they will contribute to Doctor-to-Doctor Program, World Medical Association, 10 Columbus Cir., New York, N.Y. 10019.

Family Medicine Division Created At UM Med School

The University of Miami School of Medicine has created a division of family medicine within the department of pediatrics as a result of the success of a pilot program.

Dean Hayden C. Nicholson named as division chief Dr. Lynn P. Carmichael, assistant professor of pediatrics and medicine, who originated and set up the training program two and a half years ago.

Dr. Carmichael defines family medicine as "that branch of medical science that has as its responsibility the continuing health maintenance of the family . . . occupying an intermediate position between traditional curative medicine that has as its concern the individual, and public health which concerns itself with the community."

Students take preliminary training in junior and senior years and go on to a year's internship and a two-year residency.

The program started with 10 members of the class of 1967, doubling by the class of 1968. Of 80 in the class of '69, 53 asked to participate. At present, six are interning, three in their first-year residency and one in second-year.

Preclinical Training to Get Boost at UM?

Funds earned by a non-profit foundation in caring for the aged will go toward teaching generations of new doctors through an arrangement between the University of Miami School of Medicine and a Miami convalescent home.

Under the agreement, Palmetto Foundation, Inc. estimates the school will receive upwards of $25,000 annually.

The first check, in the amount of $3,000, was presented to Dr. Hayden C. Nicholson, medical school dean and UM vice president for medical affairs, by Dr. James Hutson, foundation president. Future funds will be turned over on a quarterly basis.

Dr. Hutson represents the third generation of a Miami medical family and is a grandson of the late Dr. James M. Jackson, for whom the medical school's teaching hospital was named.

Dr. Hutson suggested the funds be allocated by the medical school dean for the preclinical instruction of doctors-to-be. Dr. Nicholson has noted this important basic training area attracts less outside financial support than subsequent clinical training or research activities.

Dr. W. D. Warren Announced New UM Medical Dean

Appointment of Dr. W. Dean Warren, professor and chairman of the department of surgery, as the new dean of the University of Miami School of Medicine was announced September 28 by UM president Henry King Stanford.

Dr. Warren succeeds Dr. Hayden C. Nicholson, who has served as medical school dean since July 1962 and also as Vice President for Medical Affairs since the first of the year. Dr. Nicholson will retain this latter position, devoting his full time to acting as liaison between the school, the university and the medical complex.

Following medical tradition which dates back to Hippocrates, the Greek "father of medicine," Dr. Warren, a native Miamian and FMA member, earned a Phi Beta Kappa key at Dartmouth College, where he got his A.B. in 1947, and the equivalent for medical scholarship, Alpha Omega Alpha at Johns Hopkins. He held a prestigious John and Mary R. Markle scholarship from 1956 to 1961.

FMA Member Honored

Dr. Wesley S. Nock, Coral Gables pediatrician and FMA member, was recently appointed a member of the Joint Committee on Health Problems in Education of the National Education Association and the American Medical Association.

Dr. Nock currently is chairman of the FMA Committee on Child Health and the School Health Medical Advisory Committee to the Florida State Department of Education and the Florida State Board of Health.

PHS Announces Coronary Drug Clinic Enrollment

The Public Health Service announced recently that the enrollment of clinics for its Coronary Drug Project has been completed with the awarding of grants totalling $1,175,062 to 19 new centers. These bring to 55 the total organizations participating in the clinical trial conducted by the National Heart Institute of the National Institutes of Health.

The Miami Heart Institute, Miami Beach, was among the 19 new centers and received a grant of $61,088. Dr. Arthur J. Gosselin is the principal investigator for the organization.

The PHS project is aimed at determining whether drugs that lower blood levels of cholesterol and other fatty substances can improve long-term survival among heart-attack victims by protecting them against recurrent heart attacks and other complications of coronary heart disease.

Members Overseas

Several Florida physicians are promoting international medical cooperation and good will through their overseas travel.

Drs. Irwin S. Leinbach, Frank A. Barlow and Paul Brady, all of St. Petersburg, departed September 4 for Yugoslavia for a series of conferences and operations. Dr. Ralph W. Jack of Miami departed September 9 to attend medical meetings in New Zealand and Australia.

Dulcolax®

sacodyl

DU-5255 R

lew drugs work as predictably
s Dulcolax. You can expect
hat when your office patient
akes Dulcolax at home, it will
le as effective as you said it
would be. Your patient will be
ratified, too.

he reliability of Dulcolax
tems from its unique mode of
ction. The drug works
irectly on nerve endings in
ne colonic mucosa, producing
ormal peristalsis throughout
ne large intestine. It does
ot rely on systemic absorption
or its effect.

his reliable action provides
rompt relief of constipation.
also makes Dulcolax par-
ticularly useful for prepping the
bowel for special procedures.
In short, it makes Dulcolax
ideal for your office practice.



Dulcolax acts so surely that the time of evacuation can often be closely predicted. Dulcolax tablets taken at night almost invariably result in a bowel movement soon after waking the following morning. Dulcolax suppositories generally work in 15 to 20 minutes, almost always within the hour.

eneral Dosage Information: *Adults:* When an ordinary laxative effect desired, 1 to 3 tablets or 1 suppository usually suffices. Tablets ust be swallowed whole, not chewed or crushed, and should not be ken within one hour of antacids or milk. *Children:* 1 or 2 tablets, epending on age and severity of condition. Tablets must not be given a child too young to swallow them whole. For infants and children der 2 years of age, half a suppository is usually effective. Above this e a whole suppository is usually advisable. Side Effects: As with any xative, abdominal cramps are occasionally noted, particularly in severely constipated persons. High dosage may result in loose, unformed stools. Contraindication: Contraindicated only in acute surgical abdomen. Availability: Tablets (5 mg.) and suppositories (10 mg.). By prescription or recommendation.

Under license from Boehringer Ingelheim G.m.b.H.

Geigy Pharmaceuticals
Division of Geigy Chemical Corporation, Ardsley, N.Y.



"Yes, Doctor, the pain is gone."

'EMPIRIN'® COMPOUND with CODEINE PHOSPHATE gr. 1/2 No. 3

Each tablet contains: Codeine Phosphate gr. ½ (Warning—May be habit forming), Phenacetin gr. 2½, Aspirin gr. 3½, Caffeine gr. ½.

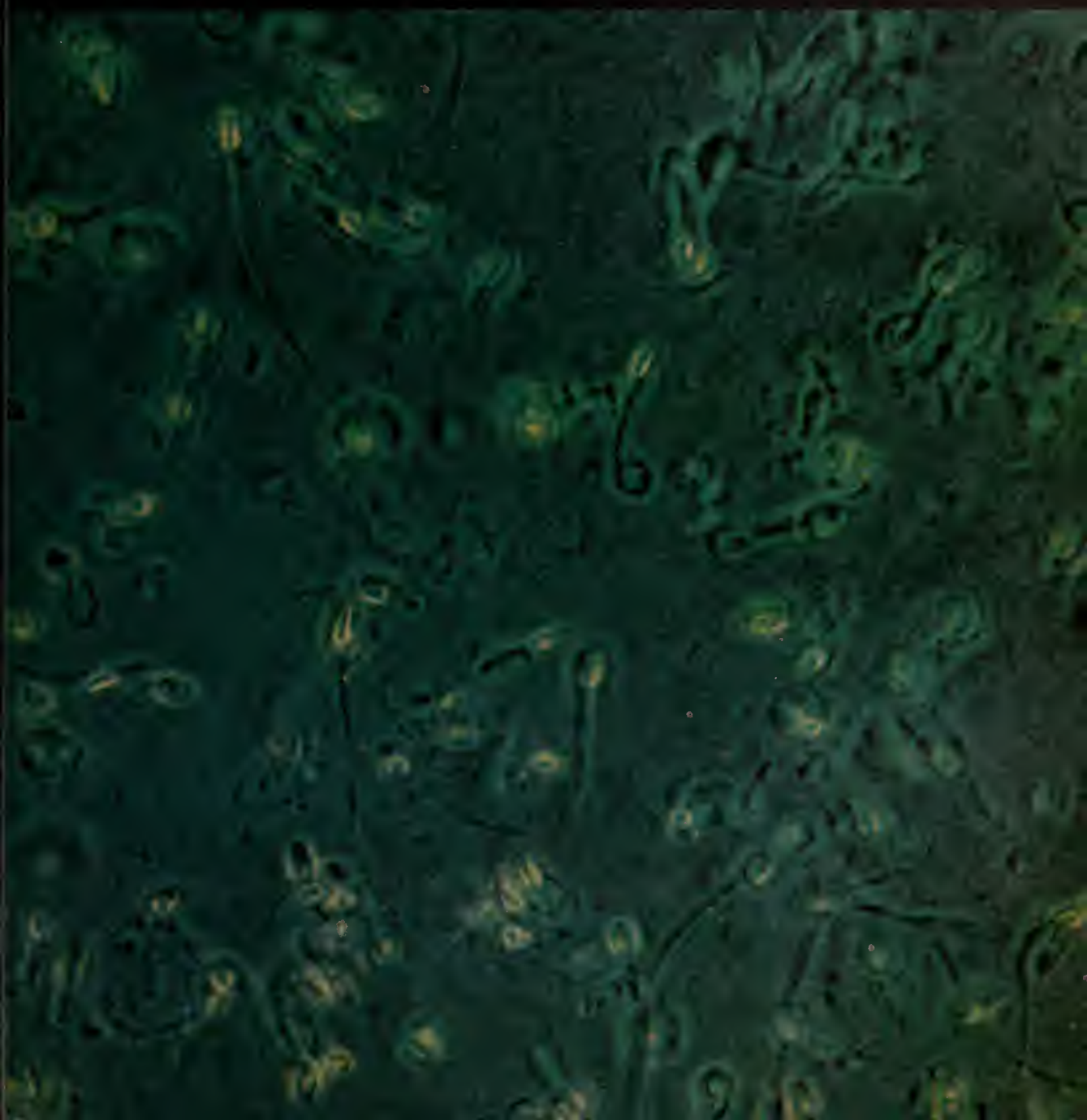
■ Despite introduction of synthetic substitutes, efficacy of 'Empirin' Compound with Codeine remains unchallenged.

BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N.Y.

When the talk turns to oral contraceptives, it makes medical sense to remember low-dose Norinyl®-1.

(norethindrone 1mg. c mestranol 0.05mg.)

Turn page for contraindications, precautions and side effec



Reduction of oral contraceptive dosage to the lowest effective levels is a well-accepted principle of conservative medical practice. In keeping with this view, Norinyl is now also available as Norinyl-1, containing exactly one half the previous dosage of norethindrone and mestranol. Clinical experience has established that effective fertility control can be achieved with the same degree of reliability and safety with new Norinyl-1 when taken as directed.

What about switching patients from higher dosage forms?

In transferring patients to low-dose Norinyl-1 from higher-dosage oral contraceptives, some breakthrough bleeding may occur in the early cycles. In the majority of cases the bleeding episode is mild and self-limited. The long-term advantages of the lower dosage form should be weighed against the inconvenience of possible breakthrough bleeding in the individual patient.

Prescribing Information

Contraindications: Patients with any symptoms or history of thrombophlebitis, pulmonary embolism, liver dysfunction or disease, carcinoma of breast or genital organs, or undiagnosed vaginal bleeding.

Warnings: Discontinue medication pending examination if there is sudden partial or complete loss of vision, proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions, medication should be withdrawn. The safety of Norinyl-1 in pregnancy has not been demonstrated. If a patient misses two consecutive periods, pregnancy should be ruled out before continuing the medication. If she has not adhered to the prescribed schedule, pregnancy should be considered at the first missed period. Active ingredients of oral contraceptives have been detected in the milk of mothers who received these drugs; the significance to infants has not been determined.

Precautions: Pretreatment physical should include examination of the breasts and pelvic organs, as well as a Papanicolaou smear. If endocrine or liver function tests are abnormal during therapy, repeat tests are recommended after the drug has been withdrawn for two months. Following administration of drug, preexisting uterine fibromyomata may increase in size. Careful observation and caution are required for patients with symptoms or history of epilepsy, migraine, asthma, cardiac or renal dysfunction, cerebrovascular accident, psychic depression, and diabetes. In cases of undiagnosed vaginal bleeding, adequate diagnostic measures are indicated. Possible long-term effects of the drug on pituitary, ovarian, adrenal, hepatic or uterine function must await further studies. The physician should be alert to the earliest manifestations of thrombophlebitis and pulmonary embolism. The drug should be used judiciously in those young patients in whom bone growth is not complete. The age of the patient constitutes no absolute limiting factor, although treatment with Norinyl-1 may mask symptoms of the climacteric. The pathologist should be advised of Norinyl-1 therapy when relevant specimens are submitted.

Side Effects: The following have been observed with varying incidence in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms, breakthrough bleeding, spotting, change in menstrual flow, amenorrhea, edema, chloasma or melasma, breast changes (tenderness, enlargement and secretion), change in weight (increase or decrease), changes in cervical erosion and cervical secretions, suppression of lactation when given immediately postpartum, cholestatic jaundice, migraine, rash (allergic), rise in blood pressure in susceptible individuals, mental depression. Although the following side effects have been reported in users of oral contraceptives, no cause and effect relationship has been established: anovulation posttreatment, premenstruallike syndrome, changes in libido, changes in appetite, cystitislike syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme, erythema nodosum, hemorrhagic eruption, and itching. The following occurrences have been observed in users of oral contraceptives (a cause and effect relationship has neither been established nor disproved): thrombophlebitis, pulmonary embolism, neuroocular lesions.

The following laboratory tests may be altered by the use of oral contraceptives: increased sulfobromophthalein and other hepatic function tests, coagulation tests (increase in prothrombin, factors VII, VIII, IX and X), thyroid function (increase in PBI and butanol extractable protein bound iodine and decrease in T^3 values), metyrapone test, pregnanediol determination.

norethindrone — an original steroid from

SYNTEX

LABORATORIES INC., PALO ALTO, CALIF.

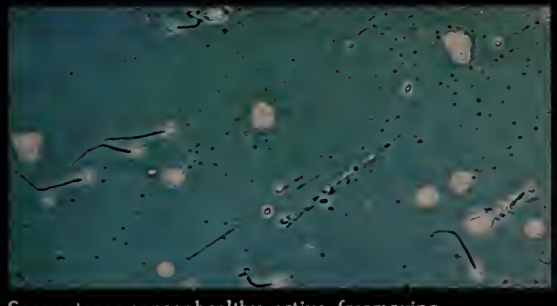
Here's why Norinyl-1 makes medical sense.

The effectiveness of Norinyl-1 as a low-dose oral contraceptive may be explained by its possible multiple action. In addition to its primary action of suppression of ovulation, Norinyl-1 may offer additional protective mechanisms... (1) creation of a cervical mucus that may be hostile to sperm penetration, and (2) development of an endometrium that may be out of phase with nidation. These effects are illustrated below.

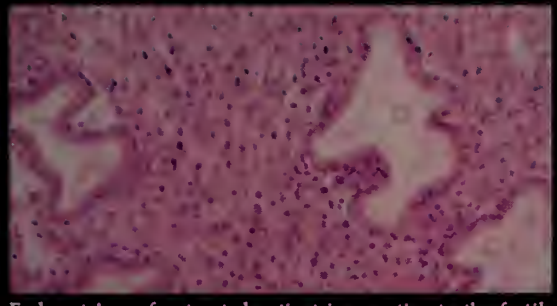
Untreated Patient



Cervical mucus at midcycle is usually thin and watery, with Spinnbarkeit (stretchability) of 15 to 20 cm.



Spermatozoa appear healthy, active, freemoving.

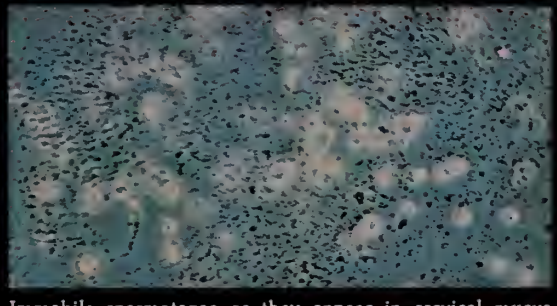


Endometrium of untreated patient is receptive to the fertilized ovum during secretory phase.

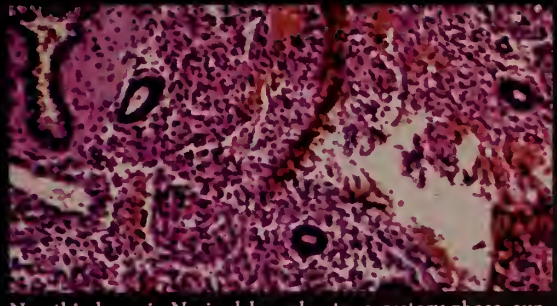
Norinyl-1 Patient



Cervical mucus at midcycle is scanty, viscous—with Spinnbarkeit of 1 cm. or less.



Immobile spermatozoa as they appear in cervical mucus taken from patient treated with Norinyl-1.



Norethindrone in Norinyl-1 accelerates secretory phase, suppresses glandular and vascular development.

Norinyl®-1
(norethindrone 1mg ē mestranol 0.05mg) tablets

- new low dose of time-proved ingredients
- established norethindrone/mestranol ratio
- lower patient cost

An uncommon steroid for common inflammatory dermatoses

In everyday topical steroid therapy, Synalar produces rapid resolution of inflammation and itching in steroid-responsive dermatoses—and at relatively low cost to the patient.

Advanced molecular design enhances potency

Synalar combines the advantage of earlier corticosteroid compounds with unique structural innovations. As a result, preparations of Synalar 0.01% and Synalar 0.025% have been reported to be more potent topically and significantly more effective than hydrocortisone 1.0%. The unique fluocinolone acetonide molecule provides one of the most useful topical corticosteroids for everyday practice.

Impressive clinical results in a wide range of dermatologic problems

The clinical efficacy of Synalar has been extensively documented in the world literature. Commonly encountered diseases such as allergic and contact dermatitis, eczematous and seborrheic dermatitis, and neurodermatitis respond rapidly to Synalar, often where previous therapy with other topical corticosteroids has failed.

Low patient cost for wider usefulness

With Synalar, a high degree of efficacy does not mean high price. And—a small quantity goes a long way. Thus, your patients can often obtain the "economy" of a hydrocortisone preparation with the proved efficacy of a potent, truly advanced steroid.

Synalar®
fluocinolone acetonide





For everyday topical steroid therapy

Synalar® 0.01%

fluocinolone acetonide provides economy in two practical dosage forms

For general use, the most economical and widely applicable concentration of Synalar is 0.01% Cream in a water-washable, vanishing cream base. Synalar Solution 0.01% is especially valuable in dermatoses involving moist, intertriginous areas or hairy sites where creams and ointments do not spread or penetrate readily. Synalar Solution is a unique dosage form—clear, nongreasy, cosmetically elegant.

Product Information

Contraindications: Tuberculous, fungal, and most viral lesions of the skin (including herpes simplex, vaccinia, and varicella). Not for ophthalmic use. Contraindicated in individuals with a history of hypersensitivity to any of the components. *Precautions:* Synalar preparations are virtually nonsensitizing and nonirritating. However, the solution may produce burning or stinging when applied to denuded or fissured areas. In some patients with dry lesions, the solution may increase dryness, scaling or itching. Where severe local infection or systemic infection exists, the use of systemic antibiotics should be considered, based on susceptibility testing. While topical steroids have not been reported to have an adverse effect on pregnancy, the safety of their use on pregnant females has not absolutely been established. Therefore, they should not be used extensively on pregnant patients, in large amounts, or for prolonged periods of time. *Side Effects:* Side effects are uncommon with topical corticosteroids. As with all drugs, however, a few patients may react unfavorably to Synalar under certain conditions. In such cases the agent should be discontinued and appropriate measures taken. *Availability:* Synalar (fluocinolone acetonide) Cream 0.025%—5, 15 and 60 Gm. tubes and 425 Gm. jars. Cream 0.01%—15, 45 and 60 Gm. tubes and 120 Gm. jars. Solution 0.01%—20 and 60 cc. plastic squeeze bottles. Ointment 0.025%—15 and 60 Gm. tubes. Neo-Synalar® (neomycin sulfate 0.5% [0.35% neomycin base], fluocinolone acetonide 0.025%) Cream—5, 15 and 60 Gm. tubes.

fluocinolone acetonide—an original steroid from

SYNTEX

LABORATORIES INC., PALO ALTO, CALIF.



In Florida - - -
These Syntex men serve the physician



William Colson
Jacksonville, Florida
721-0905



Ernest Haydel
Mobile, Alabama
342-2660



John Hidy
Margate, Florida



Robert Margolin
Miami, Florida
271-3381



James Middlemas
Pompano Beach, Florida
942-0841



B. Frank Singletary
Orlando, Florida
647-0738



Robert Vivian
Lakeland, Florida
682-3571

SYNTEX
LABORATORIES INC PALO ALTO CALIF



Public Health Topics

Did You Protect the Spread?

Since the all time lows of the mid-1950's, the annual incidence of syphilis has increased alarmingly. In 1965 over 6,000 cases were added to the lists in Florida; another 5,699 new cases were identified in 1966.

Two approaches for altering the upward trend have been lauded.

One, a community education and motivation program. Long range, this offers the best hope for reduction and ultimate elimination of the venereal diseases. People would be informed of the dangers of syphilis, made sufficiently knowledgeable of the signs and symptoms to recognize the disease in themselves or their associates and appropriately motivated to seek medical treatment. Consider the public concern for meningitis —the individual concern for hemoptysis—and the speed with which care is sought upon development of suggestive signs and symptoms.

Two, the routine practice of prophylactic treatment. This is the only hope for any immediate downward alteration of the trend. With this procedure, infectious syphilis would be prevented from developing in all persons known to have been in contact with it. Thus, the spread would be circumvented. Closely allied is the matter of "rapid epidemiology," a term becoming common in VD circles, meaning that all contacts of patients are brought to examination as rapidly as possible. Indeed, the importance of rapid epidemiology in the control of any communicable disease problem is universally acknowledged. Also acknowledged is the fact that simply treating patients has never eradicated a single epidemic disease.

The best control programs prevent cases from developing. With diphtheria, pertussis, poliomyelitis, we immunize to prevent development of cases. With hepatitis, we give gamma globulin; for meningococcal infections, we administer antibiotics; for malaria we offer prophylactic chloroquine; for rheumatic fever we inject long-acting penicillin; for tuberculin-positive contacts of tuberculosis cases, we advocate administration of isoniazid for a year. Many physicians "prevent pneumonia" as a complication of a cold by early administration of penicillin and other antibiotics. Some surgeons "prevent" postoperative infections by prophylactic use of antibiotics.

What do we do about syphilis?

Suppose a patient reported that she was sexually exposed to a penile lesion suspected of being the primary sore of syphilis. Suppose further that, in fact, the lesion was infectious syphilis.

Or—to bring the problem closer home—suppose you, a physician, were examining a penile lesion, taking a specimen for darkfield examination, and inadvertently lacerated a finger. The darkfield proved to be positive!

What will we do?

Obviously, neither of you—my hypothetical patients—have syphilis but both of you certainly have experienced a definite exposure.

We know that not all persons exposed to infectious syphilis will actually contract the disease. We know equally well that syphilis will develop within three months in up to 25% of those exposed. At the present time, there is no method for predicting in whom it will or will not develop.

It seems to me we have two possible courses of action: watchful waiting or preventive treatment. We would not forget that in an important and critical number of persons infected with Treponema pallidum local or generalized lesions will fail to develop or will be so minimal that a firm diagnosis might be delayed until seroconversion. I would note parenthetically that even undetected syphilis is contagious and capable of spread.

Of course, we would have no problem if all contacts were to refrain temporarily from sexual activity and report for proper follow-up examinations. Unfortunately, human nature does not always subscribe to modern medical practice. Contacts move away or convince themselves they are free of the disease. Meanwhile they expose others and compound the spread potential.

The dilemma is not of minor proportions. Nationally, 16.1% of the contacts to infectious syphilis are brought to treatment at the time of initial examination. Another 23.5% have recently received treatment. In 60% a decision must be made: watch or treat preventively? I submit that prophylactic therapy—epidemiologic treatment, if you will— a single injection of 2.4 million units of benzathine penicillin, is the most practicable and effective course.

Like all communicable disease measures, epidemiologic treatment must be judged by its effect on community health. One criterion, used widely, is that benefits to the community must outweigh hazards to the individual. For the community, the benefits appear obvious. For the exposed individual, hazards of treating should be compared to the hazards of not treating. It is axiomatic that all cases of paresis, tabes, optic atrophy and cardiovascular disease due to acquired syphilis, at one time, were contact cases without clinically detectable evidence of infection.

The touchy question of penicillin sensitivity or anaphylaxis arises. Such factors as a history of allergy, previous exposure to penicillin, type of penicillin product used and the number of doses to be given in any particular treatment schedule all influence the patient's chance of developing a reaction. A recent study by the U. S. Public Health Service showed that 0.9% of individuals without a history of previous untoward effects developed reactions of one kind or another. Only 0.1% of them were labeled shock-like and the great majority represented only psychogenic syncope associated with fear of the needle or painful injection. Exact figures on the actual incidence of anaphylactic shock are unavailable. Mortality is almost totally preventable if precautions are taken and careful preparations made in advance, including periodic "dry runs" with clinic personnel.

I urge you to adopt the principle of epidemiologic treatment in your management of syphilis contacts, and in fact "protect the spread" of this unnecessary and intolerable disease.

Incidentally, what was your decision for the management of your own exposure, as hypothecated?

E. Charlton Prather, M.D.
State Epidemiologist
Florida State Board of Health
Jacksonville



"George wants to know if it's okay to take his cold medicine now, Doctor, instead of seven o'clock?"



The long-continued action of Novahistine LP should help you both get a good night's sleep. Two tablets in the morning and two in the evening will usually provide round-the-clock relief by helping clear congested air passages for freer breathing. Novahistine LP also helps restore normal mucus secretion and ciliary activity—normal physiologic defenses against infection of the respiratory tract. Use cautiously in individuals with severe hypertension, diabetes mellitus, hyperthyroidism or urinary retention. Caution ambulatory patients that drowsiness may result. Each Novahistine LP tablet contains: phenylephrine hydrochloride, 25 mg., and chlorpheniramine maleate, 4 mg.

NOVAHISTINE® LP

DOW **PITMAN-MOORE** Division of The Dow Chemical Company, Indianapolis



Perhaps there have been times when you wanted to prescribe erythromycin and triple sulfas for little patients. Now you can—with a choice of two new fine-tasting pediatric forms.

New–Two Pediatric Forms of Erythromycin and Triple Sulfas





ERYTHROCIN®-SULFAS Chewable (Erythromycin ethyl succinate-trisulfapyrimidines chewable tablet)

In clinical trials[1,2], this orange-flavored tablet was given to 55 patients, aged four months to 18 years.

Diagnoses (multiple in some cases) represented a cross section of bacterial infections commonly seen in pediatric office practice.

Therapy was given from three to 12 days, with an average of six days.

Of the 55 patients, 30 were reported cured within 72 hours, while 22 showed partial recovery within the same time, and subsequent clinical cure.

A clinical cure rate of 94.5%

1. Case Reports on File, Dept. Clin. Development, Abbott Laboratories.
2. Polley, R.F.L., Use of Erythromycin-Sulfas in Office Practice, Western Med., 7:177, July, 1966.

ERYTHROCIN®-SULFAS Granules (Erythromycin ethyl succinate-trisulfapyrimidines granules for oral suspension)

87 patients were treated[1,2]—all children, ages four months to 15 years.

The diagnoses were multiple in some cases and were chiefly bacterial infections of the respiratory tract.

Dosage was maintained from three to 10 days; average treatment was five days. All of the ill children accepted the orange-flavored suspension favorably.

53 were clinically cured within 72 hours, while 32 showed partial relief within the same time, and subsequent clinical cure.

701358

A clinical cure rate of 97.7%

ABBOTT

Brief Summary on next page

ERYTHROCIN®-SULFAS
Brief Summary

Contraindications: Known sensitivity to erythromycin or sulfonamides. Because of the possibility of kernicterus with sulfonamides, do not use in pregnancy at term, premature or newborn infants.

Warnings: As with other forms of sulfonamide therapy, carefully evaluate patients with liver or kidney damage, urinary obstruction, or blood dyscrasia. Deaths have been reported from hypersensitivity reactions and blood dyscrasias following use of sulfonamides. Perform blood counts and liver and kidney function tests if used repeatedly at close intervals or for long periods.

Precautions, Side Effects: Occasionally mild abdominal discomfort, nausea or vomiting may occur with erythromycin, generally controlled by reduction of dosage. Mild allergic reactions (such as urticaria and other skin rashes) may occur. Serious allergic reactions have been extremely infrequent. Use sulfonamides with caution in patients with a history of allergy. Assure adequate fluid intake to prevent crystalluria and institute alkali therapy if indicated. If overgrowth of nonsusceptible organisms occurs, withdraw the drug and institute appropriate treatment. If a patient should show signs of hypersensitivity, appropriate countermeasures (e.g. epinephrine, steriods, etc.) should be administered and the drug withdrawn.

Adverse Reactions: Sulfonamide therapy may be associated with headache, nausea, vomiting, urticaria, diarrhea, hepatitis, pancreatitis, blood dyscrasias, neuropathy, drug fever, skin rash, injection of the conjunctiva and sclera, petechiae, purpura, hematuria and crystalluria.

Side effects due to erythromycin are infrequent, but occasional abdominal discomfort, nausea, or vomiting, urticaria and other skin rashes may occur.

Supplied: The Granules for Oral Suspension come in bottles of 60 ml. and 150 ml. The Chewable tablets are in bottles of 50. Each 5-ml. teaspoonful of reconstituted Granules or each Chewable tablet provides erythromycin ethyl succinate equivalent to 125 mg. of erythromycin activity and 167 mg. of each of sulfadiazine, sulfamerazine and sulfamethazine.

701353

ABBOTT

1044

Butazolidin®, phenylbutazone
In Acute Superficial Thrombophlebitis

Contraindications: Edema; danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. The drug should not be given when the patient is senile or when other potent drugs are given concurrently. Large doses of Butazolidin alka are contraindicated in glaucoma.

Warning: If coumarin-type anticoagulants are given simultaneously, watch for excessive increase in prothrombin time. Instances of severe bleeding have occurred. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea, sulfonamide-type agents and insulin. Carefully observe patients receiving such therapy. Use with great caution in the first trimester of pregnancy.

Precautions: Before prescribing, carefully select patients, avoiding those responsive to routine measures as well as contraindicated patients. Obtain a detailed history and a complete physical and laboratory examination, including a blood count. The patient should not exceed recommended dosage, should be closely supervised and should be warned to discontinue the drug and report immediately if fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools or other evidence of intestinal hemorrhage occur. Make regular blood counts. Discontinue the drug immediately and institute countermeasures if the white count changes significantly, granulocytes decrease, or immature forms appear. Use greater care in the elderly and in hypertensives.

Adverse Reactions: The most common are nausea, edema and drug rash. Swelling of the ankles or face may be minimized by withholding dietary salt, reduction in dosage or use of diuretics. In elderly patients and in those with hypertension the drug should be discontinued with the appearance of edema. The drug has been associated with peptic ulcer and may reactivate a latent peptic ulcer. The patient should be instructed to take doses immediately before or after meals or with milk to minimize gastric upset. Mild drug rashes frequently subside with reduction of dosage. However, rash accompanied by fever or other systemic reactions usually requires withholding medication. Purpuric rash has also been reported. Agranulocytosis, exfoliative dermatitis, Stevens-Johnson syndrome, or a generalized allergic reaction similar to serum sickness may occur and require permanent withdrawal of medication. Stomatitis, salivary gland enlargement, vomiting, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported. While not definitely attributable to the drug, a causal relationship cannot be excluded. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hyperglycemia, hepatitis, jaundice, and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently. Moderate lowering of the red cell count due to hemodilution may occur.

Dosage in Acute Superficial Thrombophlebitis: Initial: 6 capsules or tablets daily in divided doses for 2 or 3 days. Maintenance: 3 capsules or tablets daily. Usual duration of therapy is 5 to 7 days (rarely beyond 10 days). 6509-V(B)R2

*Stein, I.D.: Presented at the American Academy of General Practice, Dallas, Sept. 1967.

For complete details, please see full prescribing information.

it used to take weeks



Acute superficial thrombophlebitis before treatment



After 5 days of Butazolidin therapy

In acute superficial thrombophlebitis, patients were usually bedfast for 2 to 4 weeks, tying up hospital beds, requiring costly nursing care and time-consuming procedures such as warm soaks and packs.

When Butazolidin was added to the usual regimen, 960 of 1000 patients obtained complete resolution; most required only 30 capsules or tablets; relief of pain and discomfort and regression of inflammatory signs and fever occurred within a few days.*

Side effects occurred in 6% of the 1000 patients. While none were serious or long-lasting, Butazolidin can produce severe side effects in rare instances. Further, not every patient can take Butazolidin. Therefore, select patients with care and follow them closely. Contraindications, Warning, Precautions and Adverse Reactions are summarized in adjacent column.

Butazolidin gets bedfast thrombophlebitics out of bed, fast. Usual duration of treatment is 5 to 7 days, and rarely exceeds 10 days. Try it and see. For full details, please refer to the complete prescribing information.

Butazolidin® alka

Capsules:
phenylbutazone, 100 mg.; dried aluminum hydroxide gel, 100 mg.; magnesium trisilicate, 150 mg.; homatropine methylbromide, 1.25 mg.

Butazolidin®

phenylbutazone

Tablets of 100 mg.

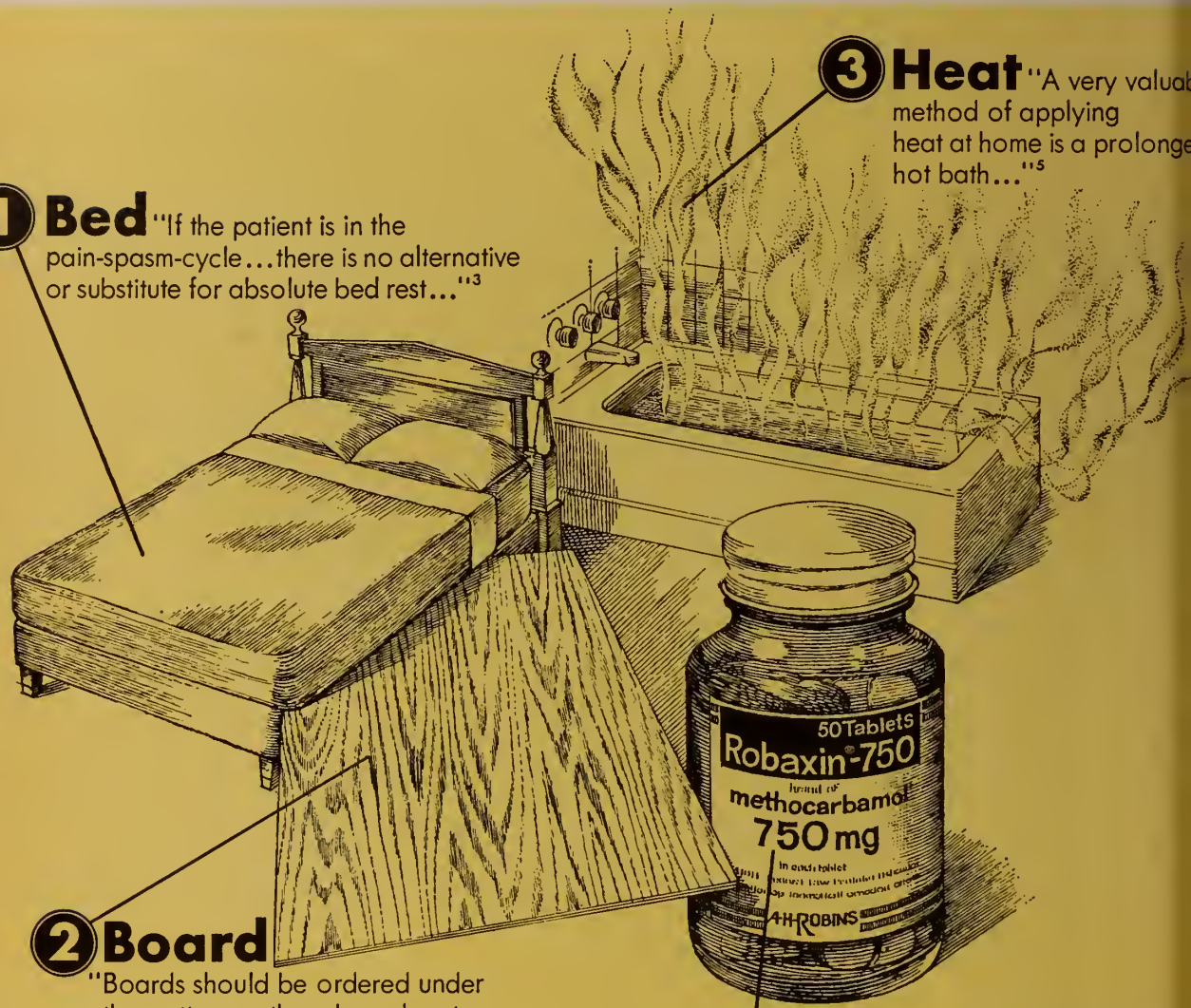
Geigy

Geigy Pharmaceuticals
Division of
Geigy Chemical Corporation
Ardsley, New York

LOW-BACK PAIN

A CONSERVATIVE, FOUR-POINT PROGRAM

The low back pain that is most frequently seen in general practice is mechanical in nature, i.e., postural back pain, joint dysfunction and acute back strain.[1,2] For this type of discomfort, a conservative regimen is usually sufficient to relieve aches and pains, and to help keep the patient functioning. Components of this basic program include:



1 Bed "If the patient is in the pain-spasm-cycle...there is no alternative or substitute for absolute bed rest..."[3]

2 Board "Boards should be ordered under the mattress...these boards act by immobilizing the spine..."[4]

3 Heat "A very valuab method of applying heat at home is a prolonge hot bath..."[5]

4 Robaxin®-750 (methocarbamol, 750 mg. capsule-shaped tablets) A well-tolerated[6] skeletal muscle relaxant, methocarbamol helps relieve spasm "...without interfering with normal tone and movement."[7] And there is little likelihood of sedation.[6]

Indicated for relief of skeletal muscle spasm. **Contraindicated** in hypersensitive patients. **Side Effects** (lightheadedness, dizziness, drowsiness, nausea) may occur rarely, but usually disappear on reduced dosage. Hypersensitivity reactions develop infrequently. See product literature for further details. **Also available:** Robaxin® Tablets (methocarbamol, 500 mg.) Robaxin Injectable (methocarbamol, 1 Gm./10 cc.)

References: (1). Godfrey, C.M.: Applied Therap. 8:950, 1966. (2). Gottschalk, L.A.: GP 33:91, 1966. (3). Rowe, M.L.: J. Occup. Med. 2:219, 1960. (4). Cozen, L.: South Dakota J. Med. 18:26, 1965. (5). Soto-Hall, R.: Med. Sc. 14:23, 1963. (6). Weiss, M. and Weiss, S.: J. Am. Osteopath. A. 62:142, 1962. (7). Feuer, S.G., *et al.*: New York J. Med. 62:1985, 1962.

A·H·ROBINS A. H. ROBINS COMPANY RICHMOND, VIRGINIA 2322

DIURESIS



MERCUHYDRIN®
(meralluride injection)

Twenty years ago the publication of "A System for the Routine Treatment of the Failing Heart"[1] established a schedule of diuretic therapy as a primary factor in the treatment of acute congestive failure. With emphasis upon daily injections of Mercuhydrin (meralluride injection) until dry weight was obtained, Gold, et al. achieved a 40% increase in improvement, in ⅓ the time, over other methods then current. Today, most medical texts continue to recommend parenteral mercurials in acute congestive failure when prompt diuresis is indicated.

Recently Modell[2] has stated: "The mercurial diuretics are the injectable diuretics of choice since they are the most potent as well as the most dependable. Their toxicity is not an important consideration either by comparison with other potent diuretics or in relation to the seriousness of the conditions in which they provide such excellent relief."

LAKESIDE

IN BRIEF

Mercuhydrin is indicated in edema of cardiac or hepatic origin and in the nephrotic syndrome; it is contraindicated in acute nephritis and in anuric or oliguric states. *The usual adult dose is one to two cc. daily or every other day until "dry weight" is obtained.* Sensitivity is rare but small initial doses are advised to minimize potential reactions; vertigo, fever, and rash have occurred. Overdosage may produce electrolyte depletion, muscle cramps, and G. I. reactions. Supplied: 1 cc. and 2 cc. ampuls in boxes of 12, 25 and 100; 10 cc. rubber capped, multiple-dose vials (intramuscular or subcutaneous use only) in boxes of 6 and 100.

1. Gold, Harry, *et al.: A System for the Routine Treatment of the Failing Heart,* The American Journal of Medicine, Vol. III, No. 6:665-692 (Dec.) 1956.

2. Modell, Walter: *Drugs of Choice 1966-1967,* p. 97, 1966.

LAKESIDE LABORATORIES, INC., Milwaukee, Wisconsin 53201

easy does it!

tear, moisten, compare–that's all!





Scientific Section

Otological Manifestations In Cleft Palate

EUGENE F. NORTHCOTT, M.D. and HUESTON C. KING, M.D.

The complex and multifaceted problems presented by cleft palate patients have necessitated the organization of an integrated program of diverse professional disciplines to evaluate properly and treat these patients. The South Florida Cleft Palate Clinic is a multidisciplinary diagnostic, treatment planning and research center similar to others developing throughout the country. In the South Florida Cleft Palate Clinic each patient is evaluated by a psychologist, speech therapist, audiologist, plastic surgeon, otolaryngologist, prosthodontist, orthodontist and general dentist. This team has as its goal not only the achievement of the best possible functional result, but also the study of all manifestations and modes of therapy of the cleft palate patient. The otolaryngologist is intimately acquainted with the structures involved and thus is able to offer a valuable contribution to the habilitation of these patients.

Since good hearing is essential for proper speech development, it is particularly important that the ear disease and resultant hearing loss in these patients be appreciated. The purpose of this paper is to report the results of the otologic and audiologic examination of the first 100 patients at the South Florida Cleft Palate Clinic.

Since no correlation exists between cleft lip and ear disease,[1] those patients with cleft lips only have been excluded. The study includes only those patients between birth and 18 years of age with cleft palates, whether treated or not.

The number of patients with unilateral or bilateral ear disease totaled 65, or 65% of the total population studied. Of these patients, 80% had bilateral and 20% unilateral disease. These figures are in excellent agreement with the distributions reported by Skolnik[2] (83% bilateral and 17% unilateral) and Graham[1] (80% bilateral and 20% unilateral) but are somewhat higher than their figures of 46% and 50% respectively for the total number of patients with ear disease.

Otological Manifestations

A detailed analysis of the various changes seen on otological examination follows. Each ear is

reported only once relative to the most prominent observable change.

Of those studied, 117 pathological ears contained four with perforations, 71 with generalized dullness, 25 with calcification or atrophic scars and 17 with active infection. Any attempt to correlate the type of pathology with the degree of hearing loss was unsuccessful. The incidence of ear disease according to age varied markedly as illustrated in Figure 1.

These findings correlate closely in distribution but not incidence with those in persons without this anomaly. Hearing loss is most apt to occur in early childhood secondary to the acute or chronic ear disease commonly present in this age group. It is believed that the anatomically shorter and straighter eustachian tube of the child is more likely to allow for ascending infections than is the eustachian tube of the older child and adult. In addition, early childhood is the period of life in which infection of the upper respiratory tract and contagious disease most commonly occur. The loss of function of the tensor palatini muscle is an added factor in the cleft palate patient.[3]

The incidence of pathological conditions of the ear shows a tendency to rise if surgical repair of the palatal cleft is delayed (Fig. 2). Only two patients above the age of three years in our series still have open palates; both have marked ear disease and a significant hearing loss. The opinion that early surgical repair has no effect on the incidence of ear disease is not supported by this study.

The importance of hypertrophic tonsils and adenoids in the etiology of middle ear infections of childhood has long been known. In the cleft palate patient the velopharyngeal closure is frequently dependent on the presence of lymphoid tissue. Any inflammatory changes in the tonsils or adenoids should be treated conservatively and as promptly as possible. The decision as to whether or not adenotonsillectomy is indicated must be highly individualized in these patients and one must always consider the effect of surgical removal of the velopharyngeal closure.[5]

Figure 3 illustrates that the presence of hypertrophic adenoid and tonsil tissue is intimately related to the development of ear infections in cleft palate patients.

Questionable cases were not included. Only those with scanty lymphoid tissue and those with obvious pathologically enlarged lymphoid tissues were included. The results of this determination are in agreement with Skolnik's findings[2] of ear disease in 84% of patients with hyperplastic tonsils and adenoids and 54% in patients with scanty lymphoid tissue.

The appearance of the eustachian tube orifice was classified into one of three types: (1) normal, (2) normal with significant lymphoid tissue, and (3) presence of a slit-like orifice only. No patient was included unless the eustachian tube ori-

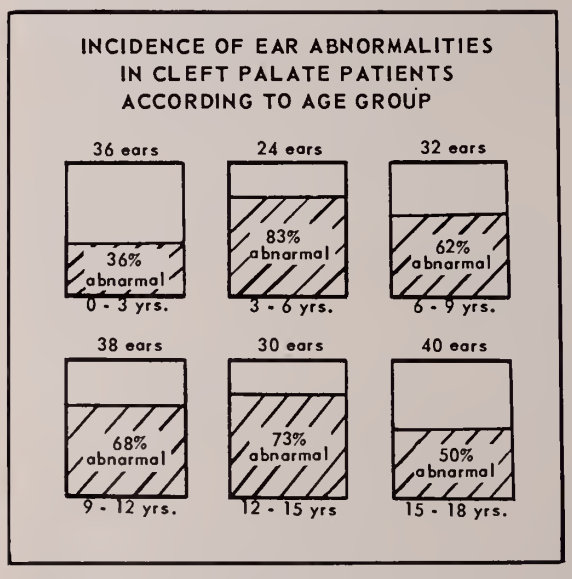


Figure 1

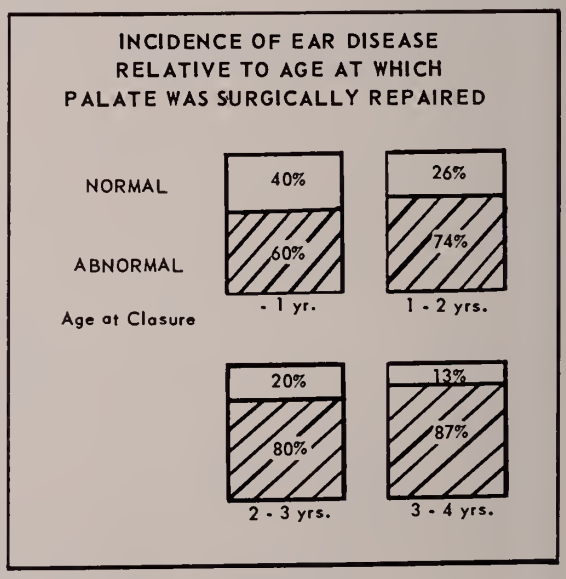


Figure 2

fices were clearly seen. Of the patients with normal eustachian tube orifices 47% had ear disease, while those with either excess lymphoid or slit-like orifices had a 60% incidence of pathologic changes.

Overall Incidence of Hearing Loss

Figure 4 presents data showing the overall incidence of hearing loss for the 82 patients in whom a reliable audiogram could be obtained. No patient under the age of four was included. The data were obtained by averaging the losses in the speech frequencies (500, 100, 200 cps) for each ear. All patients showed a conductive hearing loss.

It is readily apparent that only 3% of the total number of patients had a hearing loss in both ears which exceeded 30 dB, the level accepted as socially handicapping.

Some authorities consider a bilateral hearing loss of 15 dB or greater as significant. In this study 7.9% of the patients fell into this group.

In Graham's study[1] a significant number of the patients showed a hearing improvement after eight years of age. This study revealed that hearing tends to improve until about 13 years of age after which it levels off.

Also, it is noted that the greatest hearing losses, those in excess of 30 dB, tend to be more common in the younger age group (Fig. 5).

It is interesting to note that 35% of the abnormal ears showed a hearing loss greater than 15 dB. The opposite is also true; 8% of the apparently normal ears also showed a hearing loss greater than 15 dB. The presence or absence of pathological change, therefore, does not always reflect the state of the hearing.

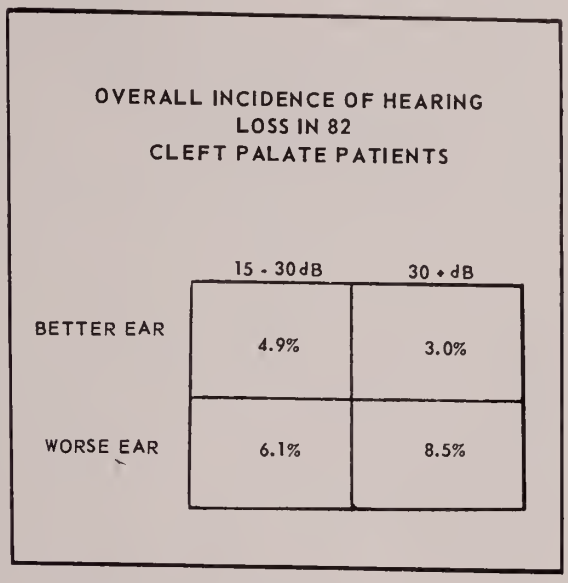


Figure 4

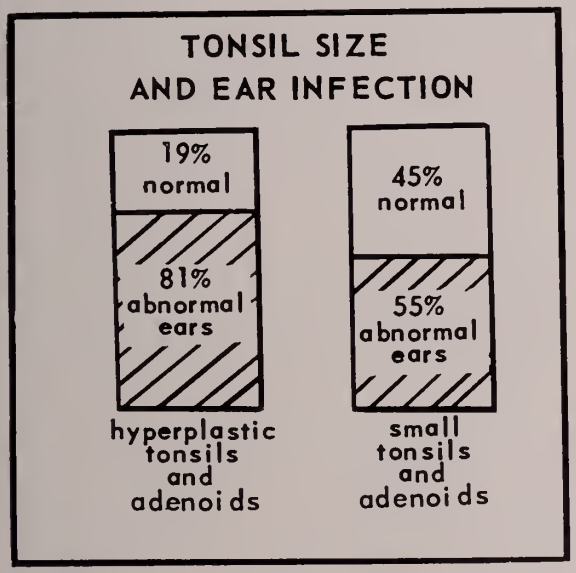


Figure 3

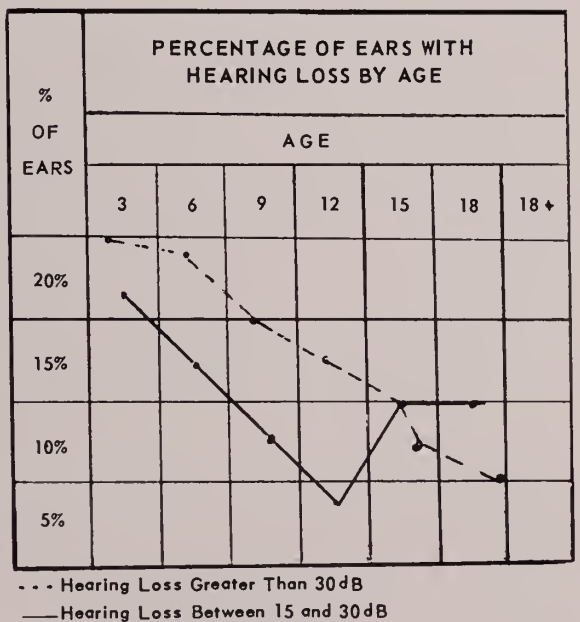


Figure 5

Conclusions

About 65% of patients with a cleft palate have evidence of pathological changes in the ear.

Of those patients with evidence of ear disease 80% have bilateral involvement.

The type of pathological change does not correlate with presence or absence of hearing loss.

Ear disease is least common in the youngest patients and reached its peak at age three to six years.

The later the palate is closed the greater the incidence of pathological changes in the ear.

Hypertrophic tonsils and adenoids add to the incidence of ear disease in cleft palate patients as they do in the general population.

Almost a quarter of the patients have a hearing loss greater than 15 dB in one ear; only 3% have a bilateral hearing loss of 30 dB or greater.

The hearing loss tends to be not only more common but also more severe in the three to six age group.

References

1. Graham, M. D.: A Longitudinal Study of Ear Disease and Hearing Loss in Patients with Cleft Lips and Palate, Trans. Amer. Acad. Ophthal. Otolaryng. 67:213-222 (Mar.-Apr.) 1963.
2. Skolnik, E. M.: Otologic Evaluation in Cleft Palate Patients, Laryngoscope 68:1908-1949, 1958.
3. Holborow, C. A.: Deafness Associated with Cleft Palate, Laryngoscope 76:762-773 (Oct.) 1962. Supported in part by P.H.S. grant DE-01836, National Institute of Dental Research.
4. Spriestersbach, D. C.; Lierle, D. M.; Moll, K. L., and Prather, W. F.: Hearing Loss in Children with Cleft Palates, Plast. Reconstr. Surg. 30:336-347 (Sept.) 1962.
5. Chalat, N. I.: Tonsillectomy, Adenoidectomy and the Cleft Palate Clinic, Laryngoscope 75:408-427 (Mar.) 1965.

▶ Dr. King, 4651 Ponce de Leon Boulevard, Miami 33134.

Deadline Nears For Annual Meeting Scientific Papers and Exhibits

Applications are now being accepted for scientific papers and exhibits to be presented before the 94th Annual Meeting of the Florida Medical Association, May 9-12 at the Diplomat Hotel, Hollywood Beach. Application forms will be included in the Briefs newsletter. Additional applications may be obtained by writing Russell B. Carson, M.D., Chairman, Committee on Scientific Assemblies, P.O. Box 2411, Jacksonville, Florida 32203.

Applications must be submitted no later than January 1, 1967. The Committee on Scientific Assemblies will make selections and notify contributors of acceptance shortly thereafter.

Important Note: All applications for scientific papers to be presented before the 94th Annual Meeting of the Florida Medical Association must be accompanied by a one page (200 word) summary of the paper prepared for publication in the Journal of the Florida Medical Association. Summaries of accepted papers will be published in the Journal prior to the Annual Meeting.

Early Care of Heart Surgery Patient After Operation

PRENTISS E. SMITH, M.D., KAZI MOBIN-UDDIN, M.D.
CARLOS R. LOMBARDO, M.D. and JAMES R. JUDE, M.D.

The patient upon whom reparative or reconstructive surgery of the heart or great vessels has been performed is a complex problem in medical and surgical management during the early period after operation. The stress of open heart surgery and the alteration in cardiorespiratory dynamics present a complicated and often confusing picture to the doctor concerned with care of the patient.

See editorial comment, page 1069

The patient, partially under anesthesia, his attention obtunded by preoccupation with pain of the operation, is usually unable to give any assistance. The biochemical and physical alterations attending the period of cardiovascular support with the pump oxygenator render him particularly sensitive to blood loss, anoxia and drug treatment. Because of the lability of his bodily processes, it is mandatory that the doctor correctly interpret all changes in the patient and treat them promptly and properly. Small errors in interpretation of available data may result in death of the patient despite a technically successful operation.

Organization of Material and Personnel

To reduce errors in management and interpretation of data to minimum, we have adopted the following program of management of patients undergoing an operation upon the heart or upon the great vessels in the chest. This program has done much to reduce the number of fatalities and chest complications resulting from inadequate care based on inadequate information and to place the treatment of these patients on a more scientific factual basis.

We believe, in addition to the usual recovery room nursing personnel, it is important to have a physician at the patient's bedside at all times for at least the first 24 hours after operation. This physician is thoroughly schooled in cardiorespiratory dynamics and in the care of these patients after operation. He observes any alteration in vital signs, interprets them as they occur and immediately copes with any difficulty which might arise. He constantly monitors the blood pressure, pulse, respiration, temperature, blood loss, venous pressure and the electrocardiogram.

The endotracheal tube used during the operation is left in place with the cuff inflated as the patient is brought to the recovery room. In the recovery room the endotracheal tube is connected to one of the positive pressure breathing devices and during the first 24 hours after operation, respiration is assisted. A plastic oropharyngeal airway is placed in the mouth beside the endotracheal tube to prevent inadvertent occlusion by the patient. The cuff of the endotracheal tube is deflated once every hour for five minutes after carefully removing secretions from the pharynx and upper airway. The endotracheal tube and plastic mouthpiece are tolerated well if movement is avoided. A few drops of lidocaine will completely abolish coughing or gagging should it occur.

There are several advantages to this procedure. Aspiration of gastric contents cannot occur

From the Division of Thoracic and Cardiovascular Surgery, University of Miami School of Medicine, Miami.
Dr. Smith is Assistant Professor, Dr. Mobin-Uddin is Instructor, Dr. Lombardo is Assistant Professor and Dr. Jude is Professor and Chief, Division of Thoracic Surgery.
This work was supported in part by U.S. Public Health Service Grants No. HE 09332-02 and HE 11024-01 and by funds from the Florida Heart Association and the Heart Association of Greater Miami.

and all secretions can be readily removed as they accumulate with a suction catheter. The patient is thereby relieved of the responsibility of coughing up secretions. A much cleaner airway can be maintained by this method with considerably less discomfort. The assisted respiration eliminates almost any possibility of atelectasis and keeps oxygenation maximal. Because the patient does not have to cough and does not have to exert muscular effort to breathe deeply, the pain of the incision is almost entirely eliminated or can be controlled with relatively small doses of intravenous analgesics. Care must be taken when deflating the cuff of the endotracheal tube, as secretions accumulate above it. When the cuff is deflated they may slip down into the tracheobronchial tree.

Arterial pressure is always monitored continually with an arterial needle or a small polyethylene catheter in the left radial artery. This catheter or needle is connected to one of the electronic blood pressure measuring devices and furnishes a moment to moment monitor of arterial pressure. This method of pressure measurement is compared frequently with the auscultatory method.

A urinary catheter is inserted to monitor the hourly urinary output for at least the first 24 hours.

A large plastic catheter is usually placed in the right external jugular vein or in the subclavian vein so that its tip lies in the right atrium. For this purpose we usually use a No. 10 sterile plastic feeding tube with multiple perforations in the distal 1.5 centimeters or the largest size intracath. This is useful for measuring central venous pressure and for rapid infusion of fluid. We have found that this is better than the inferior caval catheter inserted through the saphenous vein. The inferior caval catheter does not always give an accurate measure of the central venous pressure. The central venous pressure has been, in our experience, a most sensitive indicator of hypovolemia.

The electrocardiogram is continually monitored. We have had several cases in which the onset of ventricular fibrillation was promptly observed and the patients successfully resuscitated without permanent neurological deficit.

In the recovery room the patient remains on an automatic temperature-regulating device. This is particularly important if cerebral edema supervenes and the necessity for hypothermia arises. We also believe that hyperpyrexia in the early period after operation is harmful as the increased heart rate and oxygen consumption of the body increase the work load on the heart.

For pleural drainage we use plastic chest catheters placed in the most dependent portions of the pleural cavity. We think that these should be as large as practical. In addition, the tubes connecting to the thoracic suction machine and the drainage bottles have a volume standardization for precise moment to moment determination of the rate of blood loss.

Significance of Individual Parameters

Blood Pressure

The direct arterial catheter is used for convenience and moment to moment observation of the blood pressure. It is particularly useful in small children when the auscultatory blood pressure is difficult to obtain. It should agree closely with the auscultatory blood pressure. In some instances, the blood pressure obtained from the arterial catheter is within normal limits but the auscultatory blood pressure is difficult to hear. This usually is accompanied by evidence of peripheral vasoconstriction. The palms of the hands and soles of the feet are pale and cool and the urinary output is low. The patient may have a normally functioning central nervous system. There may be two reasons for this. The myocardium may be failing or the effective circulating blood volume may be low. The cause may be determined readily by measurement of the venous pressure. If the myocardium is failing the venous pressure will be high. A low venous pressure, however, (less than 10 cm. of saline) suggests a low circulating blood volume and is an indication for infusion of blood or fluid. The foregoing statements are particularly applicable if the blood pressure, previously audible, has become inaudible. This is usually associated with bleeding from the chest tubes in the early hours after operation.

In the period from 12 to 18 hours after operation, and in the absence of bleeding from the chest tubes, the proper fluid for replacement is plasma. Large thoracic incisions can sequester 750 to 1,500 cc. of protein-rich edema fluid around them. This condition is usually associated with a rising or stable hematocrit level.

A high venous pressure and a low blood pressure are seen with intrapericardial bleeding and pericardial tamponade. This possibility should be suspected even when the pericardium has been loosely closed and may occur at times when the pericardium has been left widely open to drain into the pleural cavity. Clots may form on the surface of the heart, adhere to the edges of the pericardium and act as an effective pericardial sac. Blood accumulates between the clot and the heart and produces pericardial tamponade. This may or may not be accompanied by bleeding from the chest tubes. It is an indication for immediate reoperation.

Pulse

The pulse should be inspected frequently for character and rate. A rapid, weak pulse may indicate an imminent fall in blood pressure and if it is accompanied by a low blood pressure and a low venous pressure, should indicate that the correct treatment is transfusion. An exceptionally slow pulse, less than 60 beats per minute, usually indicates some damage to the conduction mechanism of the myocardium. This abnormality can be readily diagnosed by the continuous electrocardiographic monitor. The pulse should be strong and full and have a rate of 80 to 100 beats per minute.

The pulse distal to the arteriotomy used for arterial inflow during cardiopulmonary bypass should be checked frequently, particularly after periods of hypotension. During hypotension this vessel is more susceptible to thrombosis. Clotting may result in loss of the limb.

Respiration

The respiration should be slow and deep, filling the lungs maximally with each inspiration. This objective is accomplished by the positive pressure breathing apparatus. Atelectasis in the first 24 hours after operation is almost entirely prevented. Assisted respiration reduces the muscular effort required for pulmonary ventilation, reduces the oxygen requirement of the body and thereby reduces the work load on the heart. It obviates all the dangers of reduced arterial oxygen saturation that attend atelectasis. It also protects against pulmonary edema should the patient be inadvertently overtransfused.

Temperature

We believe that it is beneficial to prevent hyperpyrexia. Increased body temperature increases the oxygen requirement of the body and increases the heart work required to maintain adequate circulation. A temperature of less than 100 F. is beneficial because a rapid respiratory rate and tachycardia from hyperpyrexia are prevented. Hyperpyrexia, in addition, increases the irritability of the myocardium and makes it more prone to arrhythmias.

Venous Pressure

Venous pressure is monitored continuously by connecting a large plastic right atrial or superior caval catheter to a water manometer at the patient's bedside. Using a three way stopcock, the venous pressure can be conveniently monitored during rapid infusion of fluids. After operation, the normal central venous pressure is from 14 to 18 cm. of saline above the right atrium. A high venous pressure indicates either myocardial failure or cardiac tamponade. Cardiac tamponade is usually easily diagnosed because of the wide fluctuations in blood pressure with each respiration. This is prominent when arterial blood pressure is observed on an oscilloscope. A low venous pressure is seen only with hypovolemia and we consider anything less than 12 cm. of saline as suggestive of hypovolemia and anything less than 10 cm. of saline as absolutely indicating hypovolemia.

Urinary Output

An indwelling urinary catheter is always inserted for the hourly measurement of urinary output. This may be a valuable indicator of impending hypovolemia. The urinary output begins to drop before the arterial pressure falls and some indication of the necessity for transfusion may first become apparent by a diminution in urine flow.

The character of the urine is observed constantly. For a priming material in the pump oxygenator we use 5% dextrose in water and a relative diuresis usually occurs shortly after the patient is brought to the recovery room. The urine is usually clear and light yellow. When dextrose in water is used to prime the pump, free hemoglobin in the urine is fairly common. If

free hemoglobin is detected the urine is observed for precipitation of hemoglobin and the pH of the urine is frequently obtained. If the pH is acidic, and this is usually the case with the metabolic acidosis that accompanies support by the pump oxygenator, measures are taken to alkalinize the urine to prevent further precipitation of hemoglobin.

Blood Loss

Careful attention should be paid the rate and amount of blood loss. The chest suction bottles are standardized so that a frequent determination of blood loss can be made. The tubes are frequently milked to prevent occlusion by clots. Blood loss should be of diminishing quantity. Blood loss greater than 200 cc. per hour or of increasing quantity is an indication for prompt exploration to determine the site of bleeding. We tend to reexplore early before massive transfusion is required.

Fluid Balance

The intake and output of fluid during and after operation are monitored continually, and a balance sheet of the blood loss and administered fluid is tabulated every hour. At any given time the total intake and output of a patient are known. After operation the perfusate fluid, which is a mixture of the patient's blood and the priming fluid of 5% dextrose and water, is reinfused into the patient. Studies of this fluid have indicated that it has the same hemodynamic effect as bank blood and we count it as transfusion. This fluid is, however, lost early in the period after operation as urine.

Blood Volume

The blood volume is always obtained the morning of operation and frequently after operation. This has not been, in our experience, effective in determining necessity for transfusion. We have relied more on the vital signs and the venous pressure.

Chest Roentgenograms

Chest roentgenograms are taken relatively frequently after operation, particularly if there is any indication of hypovolemia even though there is no bleeding from the chest catheters. Clots may occlude the chest catheters and no bleeding may be apparent externally, but a large collection of fluid can be seen on the chest roentgenogram. This may be an indication for immediate reoperation.

Gastrointestinal Tract

The most frequent complication in the gastrointestinal tract accompanying open heart surgery is gastric dilatation. It usually occurs 12 to 16 hours after operation and usually responds to a short period of nasogastric suction. It is usually indicated by an increased respiratory rate, restlessness and apprehension. Blood pressure and pulse usually rise slightly. The abdomen is distended, particularly in the left upper quadrant, and in young children frequently the outline of the distended stomach can be seen through the abdominal wall.

Central Nervous System

The state of the central nervous system should be observed closely. The patient, after operation, should be clear mentally as soon as the anesthetic agent has worn off. Confusion and mild restlessness may indicate beginning cerebral edema. Cerebral edema of a marked degree usually occurs from 8 to 16 hours after operation and is usually indicated by localized or generalized convulsions. During the first day after operation, convulsions are usually due to cerebral edema rather than thrombotic episodes, the latter occurring some days after operation. When signs of central nervous dysfunction appear the temperature is lowered to between 30 and 32 C. and osmotic diuretics are given.

Analgesics

All sedation, analgesics and other drugs are given by the intravenous route whenever possible. With a patient's respiration being assisted, however, it is usually not necessary to give large doses of analgesics. A solution containing 1 ml. of morphine sulfate per cubic centimeter is given slowly intravenously until the patient has no more pain. Often 2 or 3 ml. of this solution suffice to relieve pain even in large adults.

Antibiotics

Antibiotics are given in large doses intravenously for three days after operation. In addition,

intramuscular antibiotic therapy as indicated is also given. Whenever possible this is given orally after the third day.

Intravenous Fluids

During the first 24 hours after operation a maximum of 2,000 cc. of 5% dextrose in water is given. Blood is transfused as it is lost. As the bleeding from the chest catheters diminishes and becomes serous in nature, it usually becomes necessary to give 250 to 500 cc. of plasma-like fluid to make up for this and the fluid lost into the chest wall around the chest incision. It has been our experience that as much as 1,500 cc. can be sequestered about the chest incision in the first 24 to 48 hours.

Dr. Smith, University of Miami School of Medicine, Miami 33136.



Medical Inpatients' Attitudes Toward Physicians and Hospitalization

JOHN J. SCHWAB, M.D., SIDNEY B. DENMAN, Ph.D., JOSEPH F. APONTE, M.A.
and MARY HELEN BERKSHIRE, B.A.

At present, the public in the United States is showing increasing interest in the availability and quality of medical services. The physician of the future must be aware of public attitudes toward medical services.

Many writers, both lay and professional, think that the character of medical practice is changing. Sociocultural forces, such as the population explosion, new technology and fantastic advances in communication, have obviously affected medical practice as well as other facets of daily living. Also, as stated by Henry Sigerist in his essays On the History of Medicine, ". . . the characteristic features of the medical profession are determined to a very large extent by the attitude of society toward the human body and by the valuation of health and disease."[1]

Medicine today is big business; F. J. Cook in his book The Plot Against the Patient states that $36.8 billion is spent on health services annually (nearly 6% of the gross national product).[2] Group practice, health insurance programs and governmental intervention, such as Medicare, are further evidence of change. In the midst of these diverse and powerful influences we hear that patients lament nostalgically for "the doctor of the good old days." We also read that damages awarded in malpractice suits may reach sums as great as one million dollars. Although it is sometimes intimated in the popular press that the medical profession is no longer held in high regard by the public, we were unable to find studies in the literature which provide substantial data to support such a conclusion about patients' attitudes. The purpose of this paper, therefore, is to report the findings of a recent survey of medical inpatients' attitudes toward physicians and hospitalization.

Population Studied

During six consecutive weeks of the summer of 1964, 187 patients were admitted to the medical unit of the Shands Teaching Hospital of the University of Florida. We were able to obtain information about attitudes toward physicians and hospitalization from 124 patients. The remaining 63 could not be interviewed because they were too seriously ill (38), had too short a hospital stay or missed the interview (11), or were unable to communicate (14).

In the responding group, the number of males and females was almost evenly distributed: 51% male and 49% female. Approximately 90% were Caucasians and 10% were Negroes. These patients were generally representative of the population of North Florida. Their mean annual family income was reported to be $6,200 (s.d.= $5,000), and there was a considerable range in the income—from less than $1,000 to over

From the Department of Psychiatry, University of Florida College of Medicine, Gainesville.
This work was supported in part by NIMH grant MH215-02.

$15,000. Occupations were varied; the sample included professional groups, managers, proprietors, clerical workers, sales workers, service workers, laborers, housewives and retired persons. Ages ranged from 13 to 81 years (mean=48 years, s.d.=7 years); educational levels varied from no schooling through professional training, (mean = 11 years, s.d.=4 years).

Twenty per cent of these patients came from the rural areas (population less than 2,500), 40% from small towns (2,500-10,000), and 40% from cities (above 10,000). Eighty-six per cent were Protestant, 7% were Catholic, 1% were Jewish, 3% were from other religious groups and 3% had no professed religious affiliation. The overwhelming majority, 75%, were married; 13% were single, 7% were widowed, and the remaining 5% were either separated or divorced.

These patients were hospitalized for a wide variety of medical illnesses: 75% had cardiovascular, gastrointestinal, psychiatric, neurologic or endocrine illnesses.

Method

Data were obtained by trained researchers who were not working as staff members on the medical inpatient unit; they interviewed each patient privately on the third or fourth day after admission to the hospital. Prior to the interview the researcher knew only the patient's age, sex, marital status and hospital room number. A standard introduction was used. The patient was told that this was a research study of patients' attitudes and that the information would be considered confidential (not disclosed even to the medical staff in charge). The open-ended interview, which lasted for approximately one hour, was structured only to obtain the salient information—the patients' attitudes and opinions pertaining to physicians and hospitalization. Their statements were sorted into attitudinal categories and then rated on a five point scale ranging from extremely positive or favorable attitudes on one end of the continuum, through a neutral or ambivalent central position, to an extremely negative or unfavorable attitude on the opposite pole. The three raters used previously established criteria for placing a patient's attitudes into one of the response categories. These expressions of attitudes toward doctors and hospitalization were then analyzed for their overall direction and for possible relationships with various social and cultural factors.

Table 1.—Patient Attitudes Towards Physicians and Hospitalization as Expressed by 124 Hospitalized

Attitudes	Physicians	Hospitalization
	Number of Patients	
Extremely positive	53	25
Positive	51	53
Mixed or neutral	11	22
Negative	6	17
Extremely negative	3	7
	124	124

Results

As shown in Table 1, the great majority of these patients reported positive attitudes toward both physicians and hospitalization. In fact, they liked their physicians and lauded their efforts. Importantly, there was a high correlation ($r=.84$, $p<.001$) between a positive attitude toward physicians and a positive attitude toward hospitalization. As the statistical procedure indicates, those patients who held positive attitudes toward one tended to have positive attitudes toward the other, while those who expressed negative attitudes toward one tended to have negative attitudes toward the other. It should be noted, however, that a somewhat greater number of patients had more favorable attitudes toward physicians than toward hospitalization, and conversely more patients expressed negative attitudes toward hospitalization than toward physicians.

In an effort to determine whether or not various social and cultural groups differed in their attitudes, we analyzed the data for possible correlations between these attitudes and differences in age, sex, race, marital status, religious affiliation, community size, occupation, education and social status. We found no relationships, however, which were statistically significant at the .05 level of probability between attitudes and any of these factors.

Conclusions

From this study two basic findings emerged and a third is implied. First, most patients hold positive and favorable attitudes toward both physicians and hospitalization. More people had negative attitudes toward hospitalization than toward physicians; this may be explained on the basis that hospitalization is frequently impersonal

and that it is easier to vent one's dissatisfaction toward an institution than toward an individual. Many patients do feel that hospitals are threatening and confining and that the patient is a "thing," not a person, which must adapt to established routines, sacrificing even fundamental comforts such as privacy.

Second, there were no significant correlations between patients' attitudes and a large number of sociocultural factors.

Third, by implication, it appears that patients' attitudes toward medical care are derived from their personal and unique experiences with physicians and hospitals. At a time in history when many of the individual, the personal and the singular human qualities of man seem to be jeopardized by massive social and technological forces, it behooves all members of the medical profession to attend to the quality of the doctor-patient relationship.

Lastly, in previous research[3] we found that medical patients' attitudes toward their doctors were related to increased anxiety; the highly anxious patients disclosed a lack of confidence in their physicians and had less personal liking for them than did the patients with less anxiety. Also, those patients with high anxiety held negative feelings about hospitalization—even dislike—regarding it as threatening, unsafe and confining. In contrast, those with less anxiety expressed feelings of safety and security about hospitalization.

These findings add another dimension to our thoughts about medical patients' attitudes toward physicians and hospitalization. Those with emotional distress, as typified by increased anxiety, appear to be the ones who are threatened by, and therefore derogate, medical care. Besides attending to the quality of the doctor-patient relationship, the physician must provide definitive treatment for these patients' emotional illnesses. This, in turn, may change their attitudes from the adverse to the favorable.

References

1. Aponte, J. F.: The Influence of Selected Sociocultural, Psychological, and Medical Variables on Medical Patients' Perceptions of Illness, Hospitals, and Doctors, (an unpublished thesis for the degree of Master of Arts, University of Florida), (Dec.) 1965.
2. Cook, F. J.: The Plot Against the Patient, Prentice-Hall, Inc., Englewood Cliffs, New Jersey, 1967.
3. Schwab, J. J.; McGinnis, N. H.; Marder, L., and Clemmons, R. S.: Evaluating Anxiety in Medical Patients, Journal of Chronic Diseases, 19:1049-1057, 1966.
4. Sigerist, H.: On the History of Medicine, Felix Martí-Ibanez (ed.), M D Publications, Inc., New York, 1960.

▶ Dr. Schwab, University of Florida College of Medicine, Gainesville 32603.

A drug price error existed in Dr. N. Joel Ehrenkranz's manuscript "Treatment of Serious Infections Due to Common Bacteria" published on page 876 of the September 1967 Journal of the Florida Medical Association.

In Table 3, page 880, the cost of a single 250 mg. dose of Kanamycin should be $2.00 rather than $4.00, which is the cost of a 500 mg. dose, lowering the 1 Gm. adult daily dose cost from $16.00 to $8.00.

Treatment of Creeping Eruption with Orally and Topically Administered Thiabendazole

PERRY A. SPERBER, M.D.

This study is a report on the use of thiabendazole in the treatment of creeping eruption. Three separate series of cases were treated—one with oral medication, the second with topically applied thiabendazole in dimethyl sulfoxide (DMSO), and the third with topically applied thiabendazole in a special base, Estergel.

See editorial comment, page 1070

Thiabendazole has been shown to be an effective anthelmintic,[1] to possess activity against some pathogenic fungi,[2] and to be effective against the larvae of cutaneous creeping eruption.[3-5]

Treatment and Dosage

Until the advent of thiabendazole, the treatment of creeping eruption was unsatisfactory. The cornerstone of therapy has been freezing of the lesions to kill the larvae. The active portions of the lesions have been sprayed mainly with ethyl chloride, although Frigiderm and solid carbon dioxide (dry ice) have also been used to produce cryotherapy. I have found ultrasonic therapy, when judiciously used, to be of value.

Cryotherapy is painful, discomforting and not too effective. Children especially rebel against the cold stinging sensation, and most patients are very uncomfortable when the agent is used in the genitocrural, palmar and plantar areas. Usually the freezing must be repeated a number of times and often periodically. In massive infestations, a stoic fortitude is necessary to stand the repeated sprayings. Often one wonders whether finally the parasites have been killed by the cryotherapeutic procedures or by the natural termination of the disease. If the freezing is adequate to destroy the parasite, it also destroys contiguous tissues, resulting in blistering and desquamation of the integument.

Thiabendazole was initially discovered to be a potent anthelmintic, especially against roundworms of the Nematoda order, genera Strongyloides, Ascaris and Trichinella. More recently it was found to possess the property of suppressing some saprophytic fungi. In investigative studies of these activities the drug was shown to have a low level of toxicity. Moderate doses of the drug may induce emesis which seems to be caused by a central nervous system effect. This undesirable symptom may be suppressed by appropriate antiemetic drugs, but will disappear, in any case, after discontinuing thiabendazole therapy.

The recommended dosage of thiabendazole in treatment of cutaneous larva migrans is 10 mg. per pound, twice a day for two days, and total dosage should not exceed 3 Gm. per day. Table 1 lists the treatment of nine patients with cutaneous larva migrans.

Five patients with cutaneous larva migrans were topically treated with 2% thiabendazole in 90% DMSO as shown in Table 2. This therapy antedated the request of the Federal Drug Administration to discontinue all testing with DMSO.

Merck, Sharp & Dohme supplied all the thiabendazole used in this study. Merck's thiabendazole, known as Mintezol, was supplied in 500 mg. tablets. For topical use it was supplied in 2% strength in dimethyl sulfoxide of 90% concentration and also in 4% strength in Merck's Estergel base.

Table 1

No.	Sex	Age	Locale of Lesions	No. of Lesions	Pruritus	Complete Relief	Lesions Inactive	Results
1	M	40	Chest Abdomen 3 wks.	36	Severe	8 days	6 days	Excellent
2	M	27	Feet Legs 17 days	6	Severe	2 days	2 days	Excellent
3	M	27	Legs 17 days	15	Severe	2 days	2 days	Excellent
4	M	70	Hands 3 wks.	5	Severe	3 days	3 days	Excellent
5	M	22	Back Abdomen 3 wks.	26	Severe	2 days	2 days	Excellent
6	M	18	Feet Back 1 wk.	12	Severe	3 days	4 days	Excellent
7	F	11	Buttocks 4 days	3	Severe	8 days	8 days	Excellent
8	F	71	Buttocks 2 wks.	6	Severe	2 days	2 days	Excellent
9	F	13	Foot 18 days	3	Severe	3 days	3 days	Excellent

Table 2

No.	Sex	Age	Locale of Lesions	Pruritus	Complete Relief	Lesions Inactive	Results
1	F	50	Lt. foot 4 days	Severe	4 days	4 days	Excellent
2	M	27	Chest Back 5 days	Severe	7 days	2 wks.	Excellent
3	M	10	Feet 1 wk.	Severe	3 days	7 days	Excellent
4	M	36	Buttocks Back 4 days	Severe	3 days	5 days	Excellent
5	M	15	Feet 6 days	Severe	5 days	5 days	Excellent

Table 3

No.	Sex	Age	Locale of Lesions	No. of Lesions	Pruritus	Complete Relief	Lesions Inactive	Results
1	F	2	Buttocks 2 mos.	2	Severe	4 days	4 days	Excellent
2	M	1½	Buttocks 2 wks.	3	Severe	2 days	2 days	Excellent
3	M	2	Buttocks 3 mos.	6	Severe	3 days	7 days	Excellent
4	F	13	Rt. foot 1 wk.	2	Severe	3 days	5 days	Excellent
5	F	35	Rt. index finger 2 days	2	Severe	2 days	2 days	Excellent

No such testings have been done since the ban on the use of DMSO. Five patients were treated with 4% thiabendazole in Merck's Estergel base (Table 3).

Discussion

Stone and Mullins[3] were the first to report on the successful treatment of creeping eruption with oral thiabendazole. My results are confirmatory along with those of other research investigators. As shown in Table 1, complete relief from pruritus is usually noted within two to three days; actually, within 24 hours the patients are comfortable. This is most welcome when patients have been suffering with an itch for many days. Activity of the lesions declines rapidly, and usually they are quiescent within two to three days. I have used no other treatment which equals thiabendazole in producing this rapid dissolution of the lesions and disappearance of symptoms. Because of the efficacy of thiabendazole therapy, frequently only two or three days of treatment are necessary. Occasionally, in a few days to a week, some slight activity may be noted in a lesion. Retreatment will usually destroy the larva. The natural course of the disease, as I have seen it, may last for weeks or even months. Thiabendazole therapy represents a marked advance in the treatment of cutaneous larva migrans.

Side Effects

Undesirable effects, ordinarily referred to as side effects, were noted in two of the reported cases. These consisted of anorexia and nausea. In two other cases, not included in this report because therapy was discontinued by the patients, the complaints were nausea and vomiting. One of these patients, a boy of 15, simultaneously had an attack of influenza and it was believed by his mother "that the symptoms were due to the flu." In the other patient, a girl of 10, the symptoms were undoubtedly due to the drug. In any event the undesirable symptoms disappeared after stopping the drug. One female patient, aged 70, reported feeling dizzy for two hours and then the symptom completely abated.

Topical Therapy

Topical therapy with thiabendazole in DMSO applied four times daily in five cases gave complete relief within three to five days. In one patient with over 100 lesions, it took seven days. In four patients, lesions were totally inactivated in four to seven days; in the patient with over 100 lesions, it took two weeks. This was an extreme case and in retrospect the patient should have been treated with orally administered medication.

Topical therapy with thiabendazole in Estergel, applied to the skin three times daily, produced complete relief within two to five days. Lesions were completely inactivated within two to seven days.

Although this series of cases treated with topical applications of thiabendazole is small in number, indications are that the drug is equally effective regardless of whether it is incorporated in DMSO or Estergel base. No clearcut superiority of one base over the other was apparent.

Toxic Effects

No toxic effects or side effects were noted from local therapy as contrasted with oral medication. It may well be that this advantage, if continued to be borne out, may be a deciding point for topical therapy in many patients. Oral therapy seems to be slightly quicker in inactivating lesions, and so may be preferable in patients with multiple lesions or massive infestations.

Summary

Thiabendazole is an efficacious drug in the treatment of creeping eruption. It is equally effective whether administered orally or topically in DMSO or Estergel base. No toxic or side effects were observed with topical therapy in contrast to orally administered therapy.

References

1. Ferraz, W. G.; Cabeca, M.; Sarra, C., and Guimaraes, R. X.: Treatment of Strongyloidiasis and Ascariasis with Thiabendazole, Hospital (Rio) 64:1381-1388 (Dec.) 1963.
2. Blank, H., and Rebell, G.: Thiabendazole Activity Against Fungi of Dermatophytosis Mycetomas and Chromomycosis, J. Invest. Derm. 44:219-220 (Mar.) 1965.
3. Stone, O. J., and Mullins, J. F.: First Use of Thiabendazole in Creeping Eruption, Texas Rep. Biol. Med. 21:422-424, Fall 1963.
4. Katz, R.; Ziegler, J., and Blank, H.: Natural Course of Creeping Eruption and Treatment with Thiabendazole, Arch. Derm. 91:420-424 (May) 1965.
5. Merck Institute for Therapeutic Research: Thiabendazole—A. Antimycotic Properties and B. Safety Evaluation, February 1, 1965.

▶ Dr. Sperber, 536 South Ridgewood Avenue, Daytona Beach 32014.

Amebiasis in South Florida

ELIZABETH BARRETT-CONNOR, M.D. and J. WALTER BECK, Ph.D.

The following remarks have been overheard on the wards and noted in the charts of a teaching hospital: "This patient is too sick to have amebiasis alone; this patient is not sick enough to have amebiasis; amebas are harmless and can be ingested without causing any disease; the absence of eosinophilia, amebas in stool, leukocytosis or history of travel to a foreign country exclude the diagnosis of amebiasis; amebic liver abscess is usually secondarily infected with bacteria."

None of these statements are true. The apparent persistence of misconceptions about amebiasis prompted a review of recent experience with the disease at Jackson Memorial Hospital, Miami.

Materials and Methods

A review was made of the charts of patients with symptomatic amebiasis seen over the past 10 years (1956-1966). No attempt was made to include asymptomatic carriers who had cysts of Entamoeba histolytica demonstrated on routine stool examination. The propensity to treat febrile diarrhea with antibiotics and to evaluate bloody diarrhea by means of prompt barium enemas may have excluded other patients, as the use of many antibiotics or barium negates the value of stool examination.

Results

Thirty-four cases of symptomatic amebiasis were reported over the 10-year period. Twenty-nine of the patients had amebic colitis with stools positive for E. histolytica. In one patient an ameboma was demonstrated as a persistent filling defect of the ascending colon on barium enema, which cleared with antiamebic therapy alone and repeated stool examinations showed no amebas. A diagnosis of amebic liver abscess was made in four patients on the basis of anchovy-like sauce drained from the abscess or characteristic radiographic and symptomatic findings which cleared with antiamebic therapy alone. Several other probable cases were omitted because treatment had included the use of antibiotics in addition to the amebicidal drugs. A summary of the findings in 30 patients with intestinal amebiasis is presented in Table 1. Table 2 presents the findings in the four cases with amebic liver abscess. A more detailed study of the results follows.

Travel History and Diagnosis

Fifteen of the 34 patients had been in various Latin American countries from six weeks to five years prior to hospitalization. In nine the first symptoms of their present illness had developed while they were in Latin America and in the remaining six symptoms appeared from five weeks to two years after their most recent departure from a foreign country. Of the 19 patients who had never been outside of the United States, four were Seminole Indians, a group known to have a high incidence of amebiasis.[1] Six patients had a past history of dysentery, three of whom had visited or lived abroad. Two of these had been treated for amebiasis previously.

Amebiasis was correctly diagnosed on admission in 13 patients, 10 of whom had traveled outside of the United States, suggesting that a diagnosis of amebiasis may be entertained frequently

From the Department of Pathology and the Division of Infectious Diseases, Department of Medicine, University of Miami School of Medicine and Jackson Memorial Hospital, Miami
Dr. Barrett-Connor is Instructor in Medicine and Dr. Beck is Associate Professor of Pathology, both at the University of Miami School of Medicine.

Table 1.—Intestinal Amebiasis (Colitis and Amebomas)

	Age	Race	Sex	Chief Complaint	Bloody Diarrhea	Number of Stools per day	Duration Diarrhea PTA	Abdominal Pain	Temperature > 99 F.	Comment
1.	22	W	M	Diarrhea	0	6-8	1 yr.	No	No	
2.	28	W	M	Diarrhea	+	20-40	3 mos.	No	No	
3.	61	W	M	Diarrhea	+	3-10	8-10 mos.	Yes	No	
4.	3	W	F	Diarrhea	+	?	3 da.	No	104	Shigella sp.
5.	64	N	M	LUQ pain	+	?	6-8 mos.	Yes	No	
6.	14	W	M	LUQ and RUQ pain	0	2-3	7 mos.	No	101.4	
7.	46	W	F	Weakness	+	3	3 mos.	No	No	
8.	29	W	M	Diarrhea	+	7-8	5 mos.	No	No	
9.	32	W	F	Abdominal pain and diarrhea		3-5	3 mos.	No	No	
10.	42	W	F	Diarrhea and dyspareunia	+	25	3 yrs.	No	No	
11.	29	W	F	Weakness and pregnancy	0	3	?	No	No	
12.	65	N	M	Diarrhea and vomiting	+	8-9	4 mos.	Yes	No	
13.	36	W	M	RLQ and abdominal pain	0	1-2	7 mos.	Yes	No	
14.	3	W	M	Vomiting and diarrhea	+	6-8	3 mos.	No	No	Shigella sp.
15.	30	N	F	Diarrhea	+	2-3	2 wks.	No	No	
16.	24	W	M	Abdominal pain	+	3-6	6 wks.	Yes	103.8	
17.	54	N	F	Diarrhea and LLQ pain	+	20	8 mos.	Yes	No	Ameboma and colitis
18.	62	W	F	Diarrhea	+	6-8	6 da.	No	No	Ameboma
19.	22	N	F	Diarrhea and abdominal pain	+	20	7 da.	Yes	102	Perforation and death
20.	5	N	M	Diarrhea	+	4-5	5 da.	No	No	Malnutrition
21.	28	W	M	Diarrhea and abdominal pain	+	7-8	8 mos.	Yes	No	
22.	47	W	M	Diarrhea	+	4-6	1 yr.	No	No	
23.	29	W	F	Diarrhea	+	10-15	3 wks.	Yes	No	
24.	62	W	F	Diarrhea	+	24	2 wks.	Yes	104	Perforation and death
25.	2½	W	F	Diarrhea	+	?	3 mos.	No	No	
26.	30	N	M	Diarrhea and abdominal pain	+	6-8	6 mos.	Yes	No	
27.	26	N	M	Vomiting, diarrhea and pain	0	4-6	2 da.	Yes	No	
28.	2½	W	F	Vomiting and diarrhea	+	12	6 mos.	No	101	Malnutrition
29.	39	N	M	Abdominal pain and diarrhea	+	?	3 wks.	No	No	
30.	54	W	M	Diarrhea	0	5-8	2 da.	No	No	

PTA = prior to admission

Table 2.—Amebic Liver Abscess

	Age Race Sex	Chief Complaint	Diarrhea	Temperature °F.	RUQ Pain or Tenderness	Hepatomegaly	Alkaline Phosphatase (Bodansky Units)	Chest X-ray	Filling Defect on Liver Scan	E. histolytica in Stools
A.	34 WM	RUQ mass 6 mos.	+	104	+	To iliac crest	10.5	Elevated diaphragm	+	+
B.	51 WM	RLQ pain and fever 1 yr.	+	105	No	No	ND	Fixed diaphragm	+	+
C.	26 WM	RUQ pain and fever 6 da.	0	104	+	No	4.2	Pleural fluid, diaphragm elevated	+	0
D.	33 WM	Diarrhea fever and abdominal pain 8 mos.	+	102.4	+	No	8.1	Pleural fluid, elevated fixed diaphragm	ND	+

Key to terms:
WM = white male
ND = not done
RUQ = right upper quadrant
RLQ = right lower quadrant

in patients with a history of travel abroad. With one exception in all patients over 50 years of age intestinal amebiasis was diagnosed on admission as colonic carcinoma. In two fatal cases of amebic colitis, one of which was unsuspected until autopsy, the patients had never been outside of the United States. In all patients with amebic liver abscess the disease was correctly diagnosed upon admission, and all had a history of travel abroad.

The following chart shows the distribution of intestinal amebiasis and liver abscess among the foreign travelers and among those with a past history of amebiasis:

	Travel outside United States	Previous history of amebiasis
Intestinal amebiasis	11/30	1/30
Liver abscess	4/4	1/4

Intestinal Amebiasis

The age ranged from 2 to 65 years. All 30 patients had a history of diarrhea from two days to three years duration with 2 to 40 stools per day; stools were bloody in all but six patients. Abdominal pain was present in 13 patients; several patients described partial relief of pain upon defecation. Only three patients had tenesmus. A history of loss in weight, or failure to gain weight in children, was present in 15 patients and ranged from 6 to 40 pounds with a median of 15.

All but six patients were afebrile. One of two 3-year-old Indian children with Shigella sp. cultured from the stool had a temperature of 104 F. for three days. In all probability the Shigella organism rather than the E. histolytica was responsible for the acute illness. With this exception, a temperature of 102 F. or greater was reported only in patients with severe dysentery. Diffuse abdominal tenderness was noted only in these patients. Right upper quadrant tenderness was noted in six patients, four of whom had hepatomegaly. In some patients rectal tenderness was present; in one of these a mass palpable on rectal examination was demonstrated at sigmoidoscopy.

A chest x-ray was obtained in 28 cases and was abnormal in three. One 3-year-old child with shigellosis and amebiasis had bilateral pneumonitis. A second 3-year-old child had effusion in the right pleural cavity with shigellosis and amebiasis. The x-ray in both children cleared without therapy for extraintestinal amebiasis, and probably represented shigella-associated pneumonitis.[2] A 29-year-old Cuban man had pneumonia of the right lower lobe and slight elevation of

the diaphragm with normal liver function tests. This radiographic abnormality cleared prior to extraintestinal antiamebic therapy. None of these patients were believed to have had an amebic liver abscess or "amebic hepatitis."

At least one liver function test, usually an alkaline phosphatase, was performed in 17 cases. The only abnormalities noted were an alkaline phosphatase of 9.2 Bodansky units in one patient and 9.4 in another; both patients were clinically well prior to institution of therapy for extraintestinal amebiasis.

A barium enema in 15 patients revealed abnormalities in five—diverticula in one, a shaggy terminal ileum in another, a diffuse inflammation of the entire colon in a third and a contraction of the cecum in a fourth. The fifth patient with a filling defect of the ascending colon was believed to have an ameboma. The patient with diffuse inflammation on barium enema also had an inflammatory rectal mass which proved to be an ameboma. Sigmoidoscopy in 16 cases appeared normal in seven, showed hyperemia or petechial hemorrhages in three and characteristic ulcers in seven. A rectal biopsy in six cases showed E. histolytica.

Complete blood cell counts were obtained in all but one patient. White blood cell counts ranged from 6,350 to 35,800 per cubic millimeter and were not helpful diagnostically. Twenty-two of 24 patients with afebrile illness had normal white blood cell counts (less than 12,000 cells per cubic millimeter). Febrile intestinal amebiasis was associated with a leukocytosis (14,150 to 35,800 white blood cells per cubic millimeter) in every patient but the child with associated shigellosis. Marked anemia (hemoglobin less than 10 mg.%) or eosinophilia was not seen in the absence of concomitant hookworm infection or severe malnutrition. The four patients with hookworm anemia (three children and one pregnant adult) were all Indians.

Sample cases are presented to illustrate the various types of intestinal amebiasis seen.

"Simple" diarrhea type: A 42-year-old white woman had a history of up to 25 nonbloody stools per day for three years, with onset two years after a trip through Central America. There had been no fever or abdominal pain, and although she had lost 10 pounds her general health had been good. At least five admissions with extensive work-up including multiple "tap-water" enemas for parasites had been unrevealing; no laboratory abnormalities were noted. The diagnosis was functional diarrhea and depression, despite the fact that a short course of sulfa drugs had caused a three month remission. She was seen by one of us (JWB) shortly after the stools became bloody for the first time, and motile trophozoites of E. histolytica were readily demonstrated. Response to antiamebic therapy was excellent and during a five year follow-up there has been no further diarrhea.

Comment: This patient illustrates the results of tap-water enemas as a source of stool for examination. Water will lyse the trophozoites and mask the diagnosis. Two formed stools followed, if necessary, by a saline purge result in diagnostic stool examination in over 90% of cases. Once dysentery appears this is seldom necessary.

Severe amebic dysentery type: A 24-year-old Colombian man first had mild diarrhea four years prior to admission. Two years prior to admission, while in Colombia, he had dysentery and abdominal pain and was treated by a physician for "colitis" with unknown medication. He remained well until almost immediately after his arrival in the United States, when the diarrhea reappeared. Five days prior to admission stools became bloody, associated with fever, chills and severe abdominal cramps partially relieved by defecation. Motile trophozoites of E. histolytica were demonstrated on admission and he responded promptly to antiamebic therapy.

Comment: This patient was febrile with diffuse abdominal pain and leukocytosis. Failure of prompt diagnosis and treatment could have resulted in a fatal outcome, as illustrated in the following two cases.

Fulminating amebic dysentery: A 22-year-old Negro woman had never been outside of the United States. Since the age of 17 she had experienced bloody diarrhea of a few days duration approximately twice a year, frequently associated with pregnancy. Seven days prior to admission bloody diarrhea developed, and three days later she spontaneously delivered a premature infant (31 weeks). Diarrhea persisted, associated with fever, chills and generalized abdominal pain. Sigmoidoscopy on the day of admission revealed classical amebic ulcers and motile trophozoites were seen on smear. She was believed to be too sick to have amebiasis alone but not sick enough to receive emetine, and was treated for parametritis with penicillin, chloramphenicol and kanamycin. Humatin was added on the second day. The course was one of progressive deterioration. Three days after admission signs of generalized peritonitis and effusion in the right pleural cavity developed. The hemoglobin fell to 6.7 mg.% with a hematocrit reading of 23% and the potassium decreased to 1.6 mEq. A flat plate of the abdomen showed "toxic megacolon" and changes in the sigmoid shadow compatible with colitis. Culdocentesis was negative, but abdominal taps revealed yellow fluid with 4,050 leukocytes per cubic millimeter, 98% polymorphonuclear cells, 52 blood cells per cubic millimeter, and on culture grew Escherichia coli and Pseudomonas sp. Thoracentesis fluid and six blood cultures showed no pathogens. Despite emetine, blood transfusions and correction of hypokalemia on the third hospital day, the patient died the following day. Permission for autopsy was refused.

Fulminating amebic dysentery: A 62-year-old white woman had never been outside the United States and had never had diarrhea previously. She was known to have rheumatic heart disease and congestive heart failure, but otherwise was in good health until two weeks prior to admission when bloody diarrhea of up to 24 stools per day with fever and abdominal pain developed. On admission the temperature was 104 F. and there was diffuse abdomi-

nal tenderness with questionable rebound. Peritoneal tap was productive of purulent fluid, and on the second hospital day a laparotomy was performed. No stools were examined before or after the operation. The preoperative diagnosis was carcinoma of the colon with perforation; the postoperative diagnosis was necrosis of the colon of unknown etiology with multiple perforations. Despite parenteral fluids and multiple antibiotics she died on the fourth hospital day. At autopsy, amebic colitis from the sigmoid to the mid-ascending colon with multiple perforations was demonstrated.

Comment: These cases both illustrate fatal amebiasis in persons who had never left the United States. In one case the severeness of the illness was not believed secondary to amebiasis and in the other the diagnosis was not considered antemortem.

Extraintestinal Amebiasis

In contrast to the colitis patients, every patient with amebic liver abscess had traveled or lived outside of the United States, and all were males. There were four cases (Table 2) which met the criteria of anchovy pus or a response to emetine or chloroquine in the absence of other antibiotics. Cases A and B required surgical drainage of pus in addition to emetine. In case A 1,900 ml. of sterile pus was drained from an abscess extending into the left lobe after several unsuccessful attempts at aspiration of the right lobe. In case B both anchovy and foul pus was drained surgically; the purulent material was believed secondary to an episode of appendicitis one month earlier. In cases C and D both patients responded completely to emetine therapy alone; several attempts at closed needle aspiration in these two patients were unrewarding.

In contrast to the usual case of intestinal amebiasis, these patients were all febrile on admission. No patient was jaundiced on admission, but right upper quadrant tenderness pointing to liver involvement as the source of fever was present in all. All four patients had some element of pleuritic pain, and some abnormality of the right diaphragm was noted on routine chest x-ray. A single filling defect was noted on liver scan in the three patients who had this examination.

Hematologic studies suggested a more serious infection, in contrast to those with colitis (Table 3).

The patient in case C, who had been ill only six days prior to admission, was the only patient without leukocytosis and anemia on admission.

Table 3

Case	Hgb.	Hct.	WBC	%PMN	%eos.	Other parasites in stool
A	9.0	31	20,800	78	0	0
B	9.4	33	16,900	78	0	0
C	12.6	41	7,900	71	2	T. trichiura
D	8.9	—	13,950	69	6	0

In the six days of hospitalization prior to therapy anemia and leukocytosis developed comparable to the findings in the other patients.

Discussion

In natives of endemic tropical areas clinical amebiasis frequently follows migration to a new climate. Whether this development is due to change in food, climate, stress or some other factor is unknown. While it is certainly true that in the majority of cases symptomatic amebiasis is acquired in the tropics, this is of no consolation to the patient with debilitating or life-threatening infection acquired in the United States. In persons who have never traveled outside of the continental United States, acute amebiasis may be precipitated by another febrile illness, pregnancy, surgery or unknown factors. A travel history is especially important in terms of index of suspicion; its absence should by no means exclude the diagnosis.

The typical history of colitis consists of repeated bouts of diarrhea with an average of six to eight stools per day, frequently but not always bloody, and a tendency to spontaneous remission. Fever, prostration, tenesmus, colic, leukocytosis and anemia are characteristically absent in such cases; these findings result in the erroneous diagnosis of functional diarrhea, particularly in cases without dysentery.

After years of this type of rather mild disease, or abruptly as the initial manifestation, fulminating dysentery may develop. The frequency of diarrhea may not be increased over that seen in the less prostrating type of disease, but the stools often seem to be pure blood. This patient is extremely ill in appearance, with fever, marked abdominal distress and leukocytosis. Febrile amebic dysentery, in the absence of some other cause for fever, is a life-threatening disease and should be treated with all due respect and careful haste. If suspected, the diagnosis usually can be

made on the first stool examination, and there is no rationale for waiting for multiple laboratory studies. Potentially fatal complications include massive hemorrhage, perforation with acute or chronic peritonitis and metastasis to the liver.

Amebic liver abscess may present itself early or late. Characteristically, like dysentery, it occurs weeks or years after leaving the endemic area. Although not represented in our series, amebic liver abscess may arise in those who have never left the United States. Frequently a past history of dysentery is absent or remote. In about half the cases no amebas can be found on stool examination. The onset may be insidious or acute, but by the time the patient is seen by a physician fever, toxicity and a history of right upper quadrant pain or mass usually are present. If the abscess is subdiaphragmatic, or if a sympathetic or penetrating pleural effusion has occurred, the pain may be pleuritic with radiation to the shoulder, and associated with a cough. A recent review suggests that pleural pain is much more typical of amebic than pyogenic liver abscess.[3]

In contrast to pyogenic liver abscess, jaundice is rare with amebic liver disease. On physical examination the liver may be massively enlarged or completely normal in size, but there is usually punch tenderness over the liver. Frequently this is localized, and discrete swelling between the ribs over the abscess may be noted. In addition, there may be physical signs of a fixed diaphragm or pleural effusion. Fortunately, less than 20% of amebic abscesses are on the left side where symptoms and signs are bizarre and diagnosis much more difficult.[4]

In the typical abscess on the right side the chest x-ray may be normal initially but ultimately tenting and/or fixation of the diaphragm, typically medial, occurs. Pneumonia in the right lower lobe, atelectasis or pleural effusion may be noted. Liver function tests are frequently normal; the alkaline phosphatase is the most useful test in this regard.*

A liver scan may be helpful in localizing the abscess; a negative scan does not exclude the diagnosis. Closed needle aspiration over the point of maximum tenderness, the area of lucency demonstrated on liver scan, or from the eighth to ninth interspace in the anterior axillary line may reveal sterile anchovy or serosanguinous pus. The material is thick and successful aspiration requires a large bore needle. The serial use of small containers permits examination of the last amount of material removed which is most likely to contain trophozoites since they are usually found only in the edges of the abscess. Less than 15% of amebic liver abscesses are secondarily infected;[3,4] in fact, bacteriologically sterile "pus" is more characteristic of amebic liver abscess than the anchovy appearance.

Treatment

No one drug or one way to treat amebiasis has proved entirely effective. Asymptomatic intestinal disease is potentially serious and probably should always be treated. The asymptomatic or mild intestinal case can usually be cleared with one of the iodochlorhydroxyquinoline drugs or Humatin. The patient acutely ill with severe dysentery should be treated with a more rapid-acting drug; currently, tetracycline or emetine is in wide use and effective. Even though there is no evidence of liver involvement, chloroquine, ineffective against intestinal disease, should also be given to patients with colonic amebiasis to prevent later development of amebic liver abscess.

Treatment of an amebic liver abscess should always be undertaken in a hospital. Emetine or chloroquine is the drug of choice; some physicians report that both together produce the best results.[5] Occasionally patients will not respond to medical treatment alone, and require closed or open surgical drainage. Open surgical drainage should not be attempted in the absence of at least a short course of appropriate antiamebic therapy; one injection of emetine prior to attempted closed aspiration will not reduce diagnostic accuracy, and is said to minimize the dangers of any leakage of material.

Because both emetine and chloroquine are potentially toxic drugs their use should not be undertaken lightly, and they should never be employed routinely in the treatment of liver abscess "just in case the etiology is amebic." A more reasonable approach is to treat a liver abscess of unknown type (as in the case of sterile blood

*An elevated alkaline phosphatase alone in a patient with E. histolytica demonstrated on stool examination does not "prove" that the patient has amebic liver disease. This finding and/or abnormalities on chest x-ray are occasionally noted in afebrile patients who recover completely without treatment for extraintestinal amebiasis. Patients whose course and treatment are suggestive only of intestinal involvement may have tender hepatomegaly. The etiology of such findings is unknown; attempts to detect diffuse "amebic hepatitis" have been largely unrewarding.

cultures) with antibiotics first if the patient has never been outside of the United States, unless amebas are demonstrated in the stool. Patients who have traveled or lived in endemic tropical areas and who have a compatible history are treated with antiamebic therapy first, regardless of the results of stool examination. Every effort should be made to give optimal medical treatment, including closed needle aspiration, for a possible amebic liver abscess prior to surgical therapy since the latter carries a significant risk.

Summary

Case histories over the period 1956-1966 of patients with symptomatic amebiasis are reviewed.

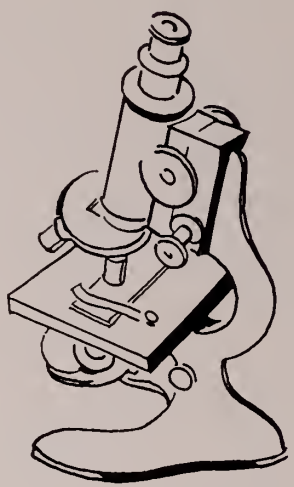
Thirty-four cases of symptomatic amebiasis are reported, 29 with amebic colitis confirmed by positive stool examination, one of which had an ameboma with amebic colitis, and one additional case of ameboma alone. Four cases of amebic liver abscess are recorded.

Tables are presented showing the laboratory and clinical findings; sample case histories of various types of intestinal amebiasis are presented, and intestinal and extraintestinal amebiasis and its therapy are discussed.

References

1. Beck, J. W.: Parasitism Among the Seminole Indians, Bull. Jackson Memorial Hosp. 13 (4):24-29, 1959.
2. Barrett-Connor, E.: Shigellosis in the Adult, J. A. M. A. 198:717-720 (Nov. 14) 1966.
3. May, R. P.; Lehmann, J. D., and Sanford, J. P.: Difficulties in Differentiating Amebic From Pyogenic Liver Abscess, Arch. Int. Med. 119:69-74, 1967.
4. Ochsner, A., and DeBakey, M.: Amebic Hepatitis and Hepatic Abscess; Analysis of 181 Cases With Review of Literature, Surgery 13:460, March; 612, April, 1943.
5. Wilmot, A. J.; Powell, S. J., and Adams, E. B.: Chloroquine Compared with Chloroquine and Emetine Combined in Amebic Liver Abscess, Am. J. Trop. Med. 8:623-624 (Nov.) 1959.

Dr. Barrett-Connor, University of Miami School of Medicine, Miami 33136.





Let's be specific about Campbell's Soups... and *reducing diets*



There are more than 30 million people in America who are overweight. During the next year, you probably will see more than 1,000 of them in your own practice.

One good way to help these patients is to give them a reducing diet based on ordinary eating patterns.

Campbell has prepared a sensible plan for weight control based on ordinary eating patterns. The plan consists of a patient instruction booklet and a set of menus which provide approximately 1,200 calories daily. The menus are balanced to provide the minimum daily requirements of nutrients.



To obtain a supply for your office write to:
Campbell Soup Company, Box 265, Camden, N. J. 08101

Conventional Radiography

The restless duodenum makes radiographic diagnosis difficult, uncertain and often unproductive: Is this duodenum abnormal?



Hypotonic Duodenography

Pro-Banthīne-induced duodenal calm permits full anatomic appraisal: Same patient. Duodenal normality is now evident.



- **in diagnosis**
- **in treatment**

Pro-Banthine® brand of propantheline bromide

calms the gastrointestinal tract

For fifteen years Pro-Banthine has been the most widely used anticholinergic agent in disorders of gastrointestinal motility and gastric hypersecretion. More recently Pro-Banthine has reestablished its pharmacologic effectiveness in diagnostic procedures using intragastric fibroscopy and hypotonic roentgenography.

How the X-rays were taken

In the hypotonic duodenograph[1,2] reproduced above, the gastrointestinal tract was relaxed with Pro-Banthine. The duodenum was intubated. Pro-Banthine in a dose of 60 mg. intramuscularly was used to assure prompt aperistalsis and double-contrast visualization was achieved with ordinary barium and air.

The same pharmacologic efficiency has proved of pronounced value in such conditions as: *peptic ulcer, pylorospasm, biliary dyskinesia, functional hypermotility and irritable colon.*

Contraindications: Glaucoma or severe cardiac disease.

Precautions: Since varying degrees of urinary hesitancy may occur in elderly males with prostatic hypertrophy, this should be watched for in such patients until they have gained some experience with the drug. Although never reported, theoretically a curare-like action may occur with possible loss of voluntary muscle control. Such patients should receive prompt and continuing artificial respiration until the drug effect has been exhausted.

Side Effects: The more common side effects, in order of incidence, are xerostomia, mydriasis, hesitancy of urination and gastric fullness.

Dosage: The maximal tolerated dosage is usually the most effective. For most *adult* patients this will be four to six 15-mg. tablets daily in divided doses. In severe conditions as many as two tablets four to six times daily may be required. Pro-Banthine (brand of propantheline bromide) is supplied as tablets of 15 mg., as prolonged-acting tablets of 30 mg. and, for parenteral use, as serum-type vials of 30 mg. The parenteral dose should be adjusted to the patient's requirement and may be up to 30 mg. or more every six hours, intramuscularly or intravenously.

(1) Bilbao, M. K.; Frische, L. H.; Rösch, J., and Dotter, C. T.: Hypotonic Duodenography, Scientific Exhibit, Radiological Society of North America, Chicago, Nov. 27–Dec. 2, 1966.

(2) Bilbao, M. K.; Frische, L. H.; Dotter, C. T., and Rösch, J.: Hypotonic Duodenography, Radiology, in press.

SEARLE

Preludin® phenmetrazine hydrochloride

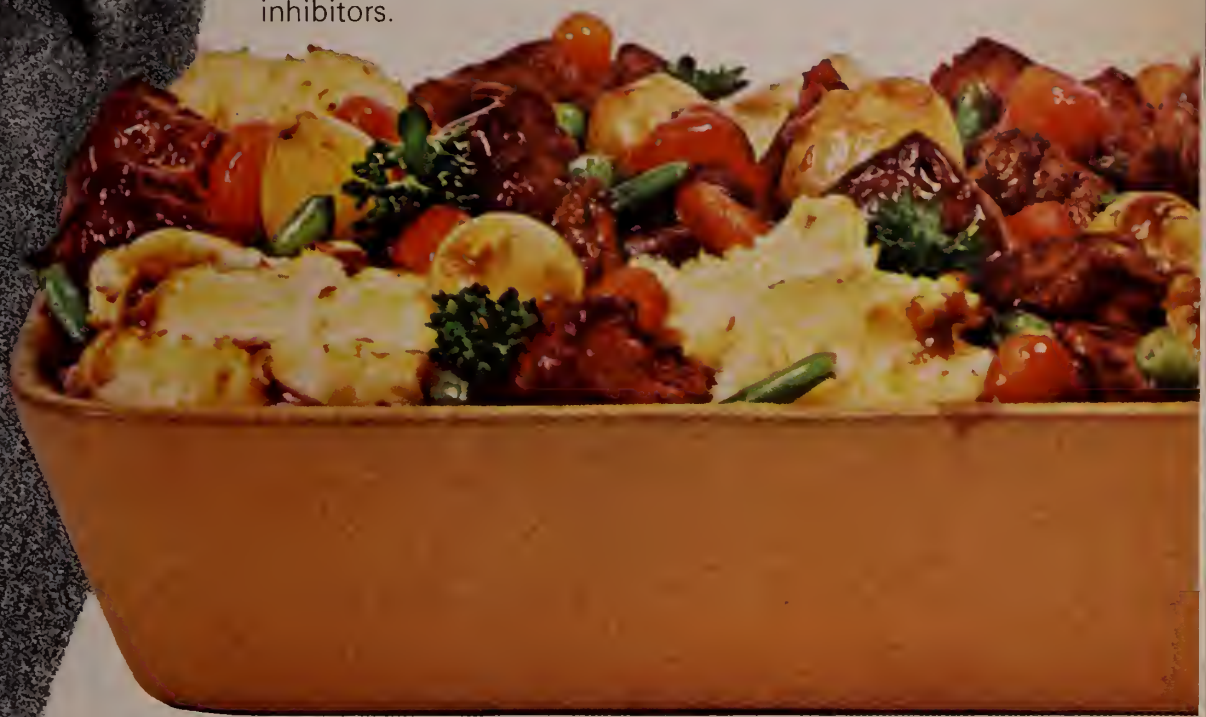


For complete details,
please see full
Prescribing Information.

helps keep calories at arm's length

Preludin is indicated only as an anorectic agent in the treatment of obesity. It may be used in simple obesity and in obesity complicated by diabetes, moderate hypertension, or pregnancy. For use in pregnancy, see Warning.

Dosage: One 25 mg. tablet b.i.d. or t.i.d. Or one 75 mg. Endurets® prolonged-action tablet a day, taken by midmorning.
Contraindications: Severe coronary artery disease, hyperthyroidism, severe hypertension, nervous instability, and agitated prepsychotic states. Do not use with other CNS stimulants, including MAO inhibitors.



Warning: Do not use during first trimester of pregnancy unless potential benefits outweigh possible risks. There have been clinical reports of congenital malformation, but causal relationship has not been proved. Animal teratogenic studies have been inconclusive.
Precautions: Use with caution in moderate hypertension and cardiac decompensation. Cases involving abuse of or dependence on phenmetrazine hydrochloride have been reported. In general, these cases were characterized by excessive consumption of the drug for its central stimulant effect, and have resulted in a psychotic illness manifested by restlessness, mood or behavior changes, hallucinations, or delusions. Do not exceed recommended dosage.
Side Effects: Dryness or unpleasant taste in the mouth, urticaria, overstimulation, insomnia, urinary frequency or nocturia, dizziness, nausea, or headache. (B)R46-560-A

Geigy Pharmaceuticals, Division of
Geigy Chemical Corporation, Ardsley, N.Y.

Under license from
Boehringer Ingelheim G.m.b.H.

Against these three major pathogens...



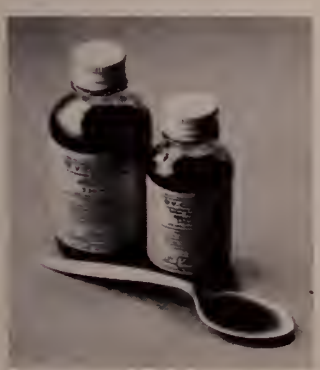
V-Cillin K® provides dependable oral antibacterial therapy

because it combines a high degree of activity...

V-Cillin K has been shown to be effective in the treatment of streptococcus and pneumococcus infections as well as infections caused by sensitive strains of staphylococci. It may be used for the prophylaxis of streptococcus infections in patients with a history of rheumatic fever and for the prevention of bacterial endocarditis after tonsillectomy in patients with a history of rheumatic fever or congenital heart disease.

with high blood levels, even when taken with food

V-Cillin K is stable in acid and immediately soluble. High serum levels, therefore, are reached rapidly. Because it is acid stable, V-Cillin K is well absorbed even when taken close to mealtime. These desirable properties help make V-Cillin K a dependable penicillin for oral use.



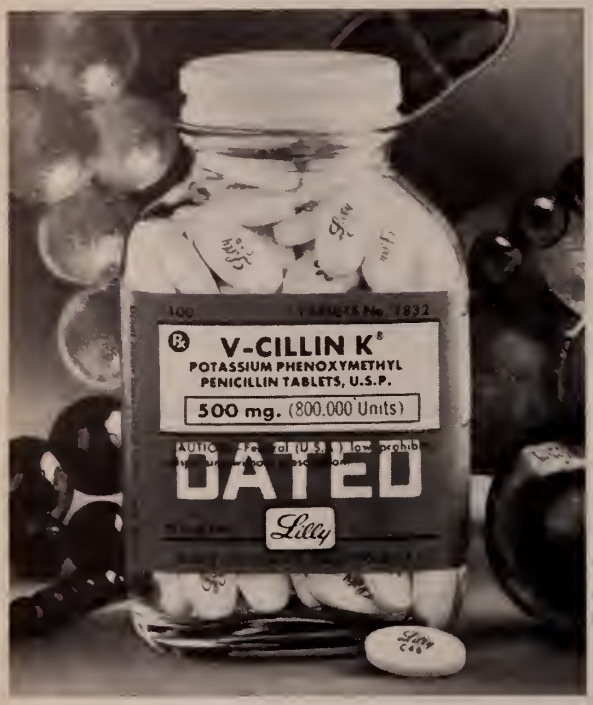
V-Cillin K® Lilly 701449

Potassium Phenoxymethyl Penicillin

Now available: V-Cillin K®, Pediatric, for Oral Solution, 250 mg. (400,000 units) per 5 cc. of solution.

(See next page for prescribing information

New 500 mg. tablets...a more convenient way to give high doses



Description: V-Cillin K, the potassium salt of V-Cillin® (phenoxymethyl penicillin, Lilly), combines acid stability with immediate solubility and rapid absorption. Higher, more rapid serum levels are obtained than with equal oral doses of penicillin G.

Indications: Streptococcus, pneumococcus, and gonococcus infections; infections caused by sensitive strains of staphylococci; praphylaxis of streptococcus infections in patients with a history of rheumatic fever; and prevention of bacterial endocarditis after tonsillectomy and tooth extraction in patients with a history of rheumatic fever or congenital heart disease.

Contraindication: Penicillin hypersensitivity.

Warnings: In rare instances, penicillin may cause acute anaphylaxis which may prove fatal unless promptly controlled. This type of reaction appears more frequently in patients with a history of sensitivity reactions to penicillin or with bronchial asthma or other allergies. Resuscitative drugs should be readily available. These include epinephrine and pressor drugs (as well as oxygen for inhalation) for immediate allergic manifestations and antihistamines and corticosteroids for delayed effects.

Precautions: Use cautiously, if at all, in a patient with a strongly positive history of allergy.

In prolonged therapy with penicillin, and particularly with high parenteral dosage schedules, frequent evaluation of the renal and hematopoietic systems is recommended.

In suspected staphylococcus infections, proper laboratory studies (including sensitivity tests) should be performed.

The use of penicillin may be associated with the overgrowth of penicillin-insensitive organisms. In such cases, discontinue administration and take appropriate measures.

Adverse Reactions: Although serious allergic reactions are much less common with oral penicillin than with intramuscular forms, manifestations of penicillin allergy may occur.

Penicillin is a substance of low toxicity, but it possesses a significant index of sensitization. The following hypersensitivity reactions have been reported: skin rashes ranging from maculopapular eruptions to exfoliative dermatitis; urticaria; and reactions resembling serum sickness, including chills, fever, edema, arthralgia, and prostration. Severe and often fatal anaphylaxis has occurred (see Warnings). Hemolytic anemia, leukopenia, thrombocytopenia, and nephropathy are rarely observed side-effects and are usually associated with high parenteral dosage.

Administration and Dosage: Usual dosage range, 125 mg. (200,000 units) three times a day to 500 mg. (800,000 units) every four hours. For infants, 50 mg. per Kg. per day divided into three doses.

See package literature for detailed dosage instructions for prophylaxis of streptococcus infections, surgery, gonorrhea, and severe infections.

How Supplied: Tablets V-Cillin K, U.S.P., 125 mg. (200,000 units), 250 mg. (400,000 units), and 500 mg. (800,000 units).

V-Cillin K, Pediatric, for Oral Solution, 125 mg. (200,000 units) and 250 mg. (400,000 units) per 5 cc. of solution (approximately one teaspoonful). [042567]

Additional information available to physicians upon request. Eli Lilly and Company, Indianapolis, Indiana 46206.

Lilly

701449

Editorials



Early Care of the Heart Surgery Patient After Operation

Most groups performing open heart surgery follow the same general theme in caring for their patients immediately postoperatively as outlined by the authors in the paper on the subject which

See scientific article, page 1051

appears earlier in the Journal. Careful observations of cardiac, respiratory and renal functions are important to permit early and, if possible, prophylactic treatment of derangements in cardiac rhythm, renal function and the composition and volume of the intravascular and extravascular fluids. There are a few points that we have found helpful in managing these patients that the authors did not mention in their excellent outline.

Postoperative care actually begins prior to operation. One of the most serious causes of arrhythmia following open heart surgery is an unusual sensitivity to digitalis preparations. We and many others have found it helpful to discontinue all cardiac medications 48 to 72 hours prior to operation. This has cut down the incidence of serious postoperative arrhythmias considerably. These drugs are started very cautiously postoperatively in small dosages with careful monitoring of the electrocardiogram before each succeeding dosage.

A second area of comment which may well have been beyond the scope of the authors' paper involves a mention of the intraoperative care of the patient. A good operation from a technical point of view that really brings about complete repair of the cardiac defects present plus careful attention to the details of hemostasis and drainage of the mediastinum, make postoperative care much simpler.

We have found it increasingly helpful to monitor hydrogen ion and base buffer composition of the blood both during operation and afterwards. The pH, pCO^2, and bicarbonate ion concentration can be easily measured on small amounts of blood obtained from arterial samples or by skin punctures. We have found these measurements essential for guidance in those patients who need mechanical support of respiration for any period of time.

In regard to ventilatory support, we have found it better to insert a Teflon nasotracheal tube at the time of operation rather than to leave the endotracheal tube in place. If the patient needs ventilatory support longer than 24 or 36 hours, a tracheostomy is performed.

Finally, the limitations in intensive care unit space and personnel have made it essential for us to individualize in regard to choosing patients for intensive monitoring. Those patients who do well initially with little or no blood loss and a quick return to a steady hemodynamic and respiratory state are returned to floor care either the night of or the day following operation. Patients in a more precarious condition are followed in a fashion

similar to that suggested by Dr. Smith and his associates.

The successful management of postoperative heart surgery patients emphasizes again the importance of careful attention to the details of patient care. Close observation of these patients in an effort to provide them with the best care possible has added much to our knowledge of the management of cardiac arrhythmias, inadequate cardiac function, derangements in acid-base balance, poor renal function and respiratory insufficiency.

Thomas D. Bartley, M.D.
Gainesville

Creeping Eruption (Larva Migrans)

Creeping eruption continues to be a problem of considerable magnitude in the Southeastern and Gulf states. Those of us who because of geographical position have to live with this affliction must be ever grateful to the late Florida dermatologist Dr. J. Lee Kirby-Smith and his colleague in public health Dr. Dove. With the cooperation of an entire community they were able to show creeping eruption to be caused by the intracutaneous migration of the larvae of the cat and dog hookworm, Ancylostoma braziliense and Ancylostoma caninum.

See scientific article, page 1059

Over 7,000 cases were reported in Florida alone in 1950. Many cases went unreported as many patients never reached a physician but were treated with diverse home remedies varying literally from the local application of peach fuzz to freezing with ethyl chloride spray. Another indication of the importance of this disease was offered by replies to a questionnaire distributed by Hitch and Iralu in 1956. From this it was learned that a dermatologist in Florida usually encounters 52 endemic cases annually, in Georgia 52, diminishing northward to three in Virginia, and westward to five in Texas.

Physicians in this area might be pardoned for waxing and waning periods of enthusiasm for various systemic treatments. Until the advent of thiabendazole (with an additional report elsewhere in this Journal) most of us had ultimately been disappointed with various methods which we had espoused.

Following scattered individual reports of the efficacy of a new systemic larvicide thiabendazole, it was the consensus that this therapeutic agent should be subjected to extensive clinical investigation. With the precedent of Kirby-Smith and Dove in establishing the etiology of creeping eruption, the Jacksonville Dermatology Society several decades later by another "community effort" established the complete reliability of this treatment. Through the combined efforts of its members and lay citizens an unusually large number of cases of creeping eruption were gathered for study in a very short period of time. An identical purpose was established and a wide base of evaluation was made available through the utilization of the opinion of all the members. Communication of ideas and results was highly developed and, lastly, a great degree of interest was established. This particular accomplishment rivaled the therapeutic achievement.

Joseph A. Farrington, M.D.
Jacksonville

Report of Ad Hoc Committee on Resolution 67-22 Blue Cross-Blue Shield

As predicted prior to the passage of legislation leading to the Medicare program, many complex problems have developed on account of this further invasion of government into the private

See Association News, page 1078

practice of medicine. Designation of Blue Cross and Blue Shield as carrier and fiscal intermediary, respectively, of Medicare Part A and Part B, afforded those charged with high quality health care in Florida a unique challenge and an unusual opportunity. It also brought many new responsibilities with the necessity for immediate expansion of personnel and facilities. The manner in which these two organizations have become adapted to the different circumstances encountered during the first year of experience with Medicare is a tribute to an efficient staff and capable management.

Some physicians are not knowledgeable concerning the basic objectives and purposes of either Blue Shield or Blue Cross. Both share a common objective—to make available a comprehensive medical and hospital prepayment service. Blue Shield is engaged in covering the services of physicians, while Blue Cross is devoted to the payment of hospital services. Although working in close cooperation in this state, they are distinctly separate organizations.

The philosophy of government and that of the private physician in attaining our common goal differ widely. The former, under the guise of public service, deals with groups; the latter is much more interested in welfare of the individual, his patient. The future of health care depends upon whether the concept of high quality can be maintained as a reality while the costs rise and the need to control costs increases. The practicing physician has a central role and responsibility with the individual patient in the maintenance of this high quality care.

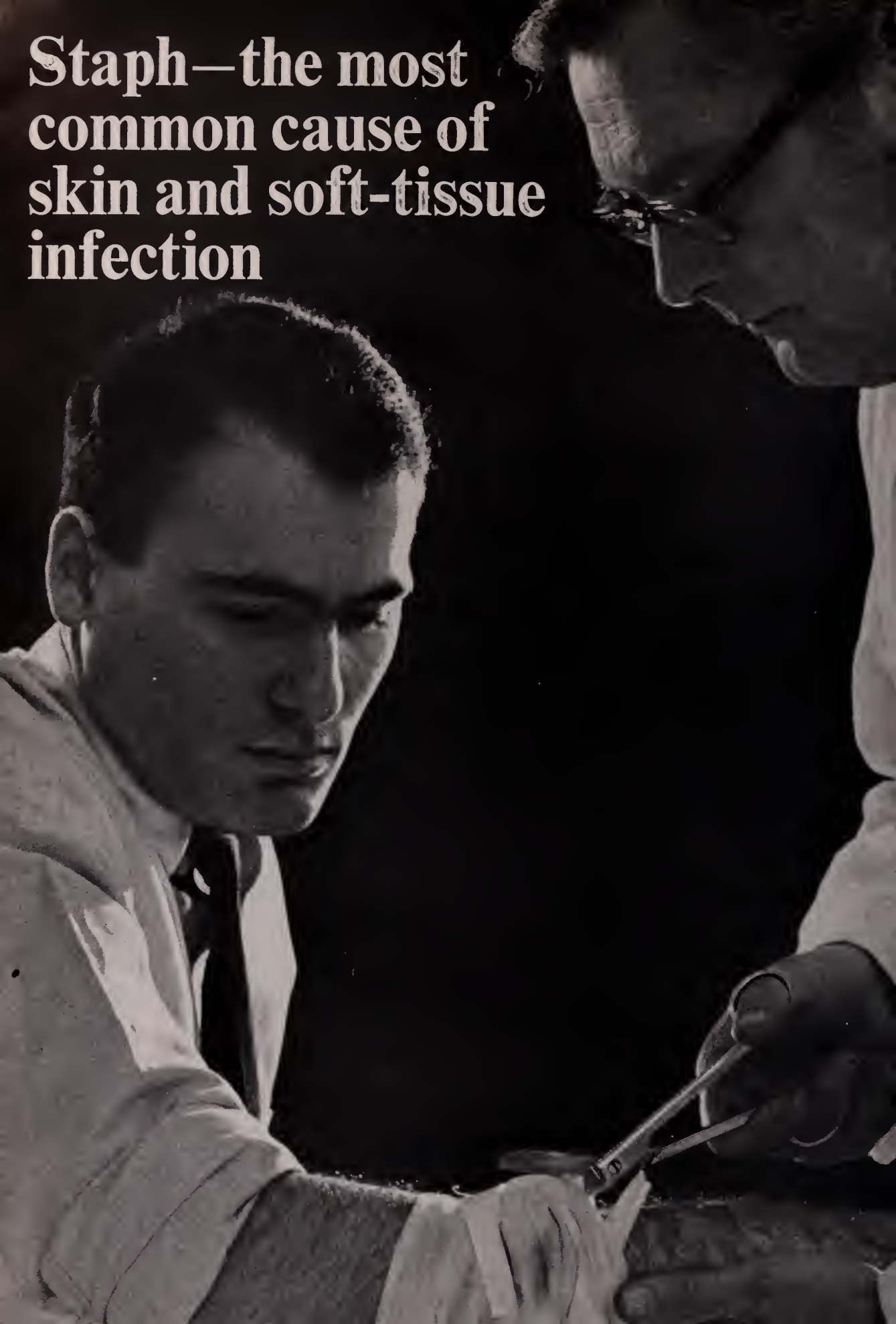
With increased participation of the federal government in the provision and financing of medical and hospital care for increasing numbers of persons it is anticipated that one of the major problems of the future for organized medicine will be maintaining for the physician his freedom of judgment and freedom of action. Some of these federal programs are now undergoing implementation. The source of leadership should be the physicians of the community involved. Physicians and hospital administrators must exercise intelligent guidance as a team in leading others through this confusion born of rapid expansion and multiple responsibility. It is only by concerted effort as a team that we can together control the destiny of private medicine and prevent further encroachment of governmental mass power. The American Medical Association officially has offered this type of help to the government, and has been able to influence favorably certain legislative changes for the good of the patient. This should be the basic position of organized medicine in any controversy which may develop.

It is heartening to learn from the Committee's report that both Blue Shield and Blue Cross of Florida are working together in accordance with the fundamental principles for which they were founded. There is no evidence at this time of domination by federal control in the policies or actions of either organization.

"God grant me the serenity to accept the things I cannot change; courage to change the things I can; and wisdom to know the difference."

Warren W. Quillian, M.D.
Miami

Staph—the most common cause of skin and soft-tissue infection



reliably controlled with specific therapy



A suitable dosage form for every staph situation

Staph—the most common cause of skin and soft-tissue infection—also is responsible for many more serious infections, such as pneumonia, osteomyelitis, and septicemia. Often, a seemingly minor skin infection is the source of metastatic spread to deeper structures. When findings on culture incriminate staph as the cause, Prostaphlin (sodium oxacillin) will provide specific effective therapy.

Bactericidal effectiveness. Hardly a staph organism can resist the bactericidal action of Prostaphlin (sodium oxacillin), as shown by a 34-month *in vitro* study. Of all staph isolates tested, 99.5% were sensitive to oxacillin.[1]

Clinically proven. There is a high correlation between these *in vitro* findings and clinical results. Of 610 patients treated with Prostaphlin (sodium oxacillin), 89.8% were reported cured or improved, including those with staph infections resistant to penicillin G.[2] And since resistance does not appear to develop *in vivo*, therapy with oxacillin can be extended when necessary.

Outstanding safety record. Besides being staph-specific and rapidly absorbed—Prostaphlin (sodium oxacillin) has established an outstanding record of safety during five years of widespread clinical use. Continuous high blood levels of oxacillin have not produced toxic effects on kidney function, assuring a significant margin of safety. However, as with all penicillins, the possibility of allergic response should be considered.

Capsules, Oral Solution and Injectable. Prostaphlin (sodium oxacillin) is available in three flexible dosage forms to suit the age of the patient and severity of infection—capsules, an oral solution for pediatric use, and multi-dose vials for injection, I.M. or I.V.

PRESCRIBING INFORMATION: For complete information, consult Official Package Circular. *Indications:* Infections caused by Staphylococci, particularly those due to penicillin G-resistant Staphylococci. *Contraindications:* A history of severe allergic reactions to penicillin. *Precautions:* Typical penicillin-allergic reactions may occur. Safety for use in pregnancy and premature infants is not established. Because of limited experience, use cautiously and evaluate organ system function frequently in neonates. Mycotic or bacterial superinfections may occur. Assess renal, hematopoietic and hepatic function intermittently during long-term therapy. *Adverse Reactions:* Skin rashes, pruritus, urticaria, eosinophilia, nausea, vomiting, diarrhea, fever and occasional anaphylaxis. Rare cases of reversible hepatocellular dysfunction have occurred. Moderate SGOT elevations have been noted. Thrombophlebitis has occurred occasionally during intravenous therapy and leukopenia was noted in two cases. *Usual Oral Dosage:* Adults: 500 mg. *q.*4 or *q.*6*h.* Children: 50 mg./Kg./day. *Usual Parenteral Dosage:* Adults: 250-500 mg. *q.*4 or *q.*6*h.* Children: 50 mg./Kg./day. Treat beta-hemolytic streptococcal infections for at least 10 days. Give oral drug 1 to 2 hours before meals. *Supplied:* Capsules—250 and 500 mg. in bottles of 48. Injectable—250 mg., 500 mg., and 1 Gm. dry filled vial for I.M./I.V. use. For Oral Solution—100 ml. bottle, 250 mg./5 ml. when reconstituted. **A.H.F.S. CATEGORY 8:12.16**

References: 1. Abstracted from *Antibiotic Sensitivity of Staphylococci Studied from November 1962 through August 1965,* reported by Griffith, L.J., Staphylococcus Reference Laboratory, V.A. Hospital, Batavia, N.Y. 2. Data on file, Bristol Laboratories.

BRISTOL

BRISTOL LABORATORIES/Division of Bristol-Myers Co., Syracuse, N.Y.

Whenever you suspect staph PROSTAPHLIN®
SODIUM OXACILLIN



Government News

AMA Medicare and Medicaid Changes Approved by House Committee

The House Ways and Means Committee approved a social security bill including some Medicare and Medicaid changes sought by the medical profession and excluding others opposed by the American Medical Association.

The committee also discarded an Administration proposal to extend Medicare coverage to disabled workers under age 65, as well as an Administration-opposed proposal that would have put federal government workers under Medicare. The actions were part of a general scaling down of the increases in social security benefits sought by President Johnson.

A committee bill (H.R. 12080) included these changes in the present law:

—Allow Medicare patients, or doctors, to collect from the government on the basis of an itemized bill. Present law requires a bill receipted as having been paid to the doctor if the doctor does not accept an assignment. (AMA-supported)

—Authorize states to allow physicians to bill Medicaid patients directly if they are not also cash assistance recipients. (AMA-supported)

—Eliminate the requirement for certification by a doctor before admission of a Medicare patient to a hospital. (AMA-supported)

—Shift coverage on Medicare outpatient diagnostic services provided by hospitals from Plan A to Plan B. (AMA-supported)

—Put limits on federal contributions to states for Medicaid programs. Beginning July 1, 1968, the federal ceiling on eligibility would be 150% of the annual income set by a state for welfare eligibility. It would drop to 140% on January 1, 1969, and to 133-1/3% January 1, 1970.

—Require states to give birth control information to welfare patients who request it.

In addition to opposing extension of Medicare to disabled workers under age 65, the AMA opposed creation of a new Plan C under Medicare and a provision for chiropractor's services—both of which were rejected by the committee.

The House group slashed back the President's proposal for a 15% minimum monthly social security increase in cash benefits to 12.5%. The Administration proposal for an increase in social security taxes also was scaled down to 4.4%, on the employer and on the employee, of the first $7,600 in wages starting in 1968. The taxable wage base now is $6,600, and the tax rate is 4.4%. The Administration had asked that the base be increased to $7,800 next year, and in later stages, to $10,800.

Lung Cancer Task Force Appointed By Federal Government

The federal government has stepped up its campaign against cigarette smoking with the issuance of a new report and the appointment of a Lung Cancer Task Force.

A second Public Health Service report on the subject summarizes three and one-half years of research and study into the health dangers of smoking. The Department of Health, Education, and Welfare said the report confirms and strengthens the conclusions of a 1964 report. The second report provides new technical data on the relationship of smoking to cardiovascular, chronic bronchopulmonary disease, cancer and other conditions.

—Cigarette smokers have substantially higher rates of death and disability than their nonsmoking counterparts in the population. This means that cigarette smokers tend to die at earlier ages and experience more days of disability than comparable nonsmokers.

—A substantial portion of earlier deaths and excess disability would not have occurred if those affected had never smoked.

—If it were not for cigarette smoking, practically none of the earlier deaths from lung cancer would have occurred; nor a substantial portion of the earlier deaths from chronic bronchopulmonary diseases (commonly diagnosed as chronic bronchitis or pulmonary emphysema or both); nor a portion of the earlier deaths of cardiovascular origin. Excess disability from chronic pulmonary and cardiovascular diseases would also be less.

—Cessation or appreciable reduction of cigarette smoking could delay or avert a substantial portion of deaths which occur from lung cancer, a substantial portion of the earlier deaths and excess disability from chronic bronchopulmonary diseases, and a portion of the earlier deaths and excess disability of cardiovascular origin.



Recognize this?
Chloresium® Ointment
—it's recognized for effectiveness in healing ulcers, soothing burns, deodorizing wounds. Use this coupon for samples. Rystan

Chloresium Ointment
Brand of water-soluble chlorophyll derivatives

RYSTAN COMPANY (F)
117 Mt. Vernon Ave.
Mt. Vernon, New York
Please send me literature and free samples of CHLORESIUM OINTMENT

Dr. _____

Street _____

City _____ State _____ Zip _____

IRON DEFICIENCY

ANEMIA



Imferon®

(iron dextran injection)

There's as much iron . . . 250 mg. . . . in a 5 cc. ampul of Imferon (iron dextran injection) as in a pint of whole blood. When iron deficient patients are intolerant of oral iron . . . or orally administered iron proves ineffective or impractical . . . or if the patient cannot be relied upon to take oral iron as prescribed, Imferon (iron dextran injection) dependably increases hemoglobin and rapidly replenishes iron reserves. Precise dosage is easily calculated.

LAKESIDE

IN BRIEF: ACTION AND USES: A single dose of Imferon (iron dextran injection) will measurably begin to raise hemoglobin and a complete course of therapy will effectively rebuild iron reserves. The drug is indicated only for specifically-diagnosed cases of iron deficiency anemia and then only when oral administration of iron is ineffective or impractical. Such iron deficiency may include: patients in the last trimester of pregnancy; patients with gastrointestinal disease or those recovering from gastrointestinal surgery; patients with chronic bleeding with continual and extensive iron losses not rapidly replenishable with oral iron; patients intolerant of blood transfusion as a source of iron; infants with hypochromic anemia; patients who cannot be relied upon to take oral iron.

COMPOSITION: Imferon (iron dextran injection) is a well-tolerated solution of iron dextran complex providing an equivalent of 50 mg. in each cc. The solution contains 0.9% sodium chloride and has a pH of 5.2-6.0. The 10 cc. vial contains 0.5% phenol as a preservative.

ADMINISTRATION AND DOSAGE: Dosage, based upon body weight and Gm. Hb/100 cc. of blood, ranges from 0.5 cc. in infants to 5.0 cc. in adults, daily, every other day, or weekly. Initial test doses are advisable. The total iron requirement for the individual patient is readily obtainable from the dosage chart in the package insert. Deep intramuscular injection in the upper outer quadrant of the buttock, using a Z-track technique, (with displacement of the skin laterally prior to injection), insures absorption and will help avoid staining of the skin. A 2-inch needle is recommended for the adult of average size.

SIDE EFFECTS: Local and systemic side effects are few. Staining of the skin may occur. Excessive dosage, beyond the calculated need, may cause hemosiderosis. Although allergic or anaphylactoid reactions are not common, occasional severe reactions have been observed, including three fatal reactions which may have been due to Imferon (iron dextran injection). Urticaria, arthralgia, lymphadenopathy, nausea, headache and fever have occasionally been reported.

PRECAUTIONS: If sensitivity to test doses is manifested, the drug should not be given. Imferon (iron dextran injection) must be administered by deep intramuscular injection only. Inject only in the upper outer quadrant of the buttock, not in the arm or other exposed area.

CONTRAINDICATIONS: Imferon (iron dextran injection) is contraindicated in patients sensitive to iron dextran complex. Since its use is intended for the treatment of iron deficiency anemia only it is contraindicated in other anemias.

CARCINOGENICITY POTENTIAL: Using relatively massive doses, Imferon (iron dextran injection) has been shown to produce sarcoma in rats, mice and rabbits and possibly in hamsters, but not in guinea pigs. The risk of carcinogenesis, if any in man, following recommended therapy with Imferon (iron dextran injection) appears to be extremely small.

SUPPLIED: 2 cc. ampuls, boxes of 10; 5 cc. ampuls, boxes of 4; 10 cc. multiple dose vials.

LAKESIDE LABORATORIES, INC., Milwaukee, Wisconsin 53201

A Building Block approach to treating hypertension

With these three therapeutic building blocks you can create a once-a-day regimen to fit almost any degree of hypertension. See the following pages for details . . .



Consider starting your hypertensives on this basic thiazide

ABBOTT

A single daily dose of Enduron provides sodium excretion around the clock

Enduron is a true 24-hour single-dose thiazide. Its sodium excretion is not squeezed into an abrupt peak during the first several hours. It is well-sustained in a plateau-like effect—with little reduction for the first 12 hours, and decline thereafter only gradual.

Potassium loss, by contrast, is low. It reaches an early minor peak, then subsides rapidly. Moreover, since dosage is but once a day, there is but one daily peak of potassium loss. As with all thiazides, however, dietary potassium supplementation should also be considered, especially in long or intensive therapy.

Use Enduron as an ideal starting therapy in mild hypertension. Use it too, as a basic therapeutic building block with which other agents can be joined, for managing your more resistant hypertensives.



Once a day, every day

ENDURON®
METHYCLOTHIAZIDE

DAILY DOSAGE RANGE	Minimum	Usual	Intermediate	Maximum
	2.5 mg. tablet	5 mg. tablet	7.5 mg.	10 mg.

See Brief Summary on final page of advertisement.

To build added response, shift to Enduronyl

The deserpidine component adds enhanced antihypertensive activity

The rauwolfia component of Enduronyl is deserpidine (Harmonyl®), a purified crystalline alkaloid supplied only by Abbott. It augments Enduron with its own antihypertensive and tranquilizing action.

Thus the combined clinical effect of these two therapeutic building blocks in Enduronyl is greater than can ordinarily be achieved with either alone.

To add flexibility, Enduronyl comes in two strengths: regular and Forte. Both provide 5 mg. of Enduron. The variation is where most helpful: in the deserpidine. The tablets are scored, and give a surprisingly wide and economical choice of once-a-day doses (see below).

Choose Enduronyl for your patients in the broad range of mild to moderate hypertension. Patient acceptance is excellent!



Once a day, every day

ENDURONYL®

METHYCLOTHIAZIDE 5 MG. WITH DESERPIDINE 0.25 MG.

ENDURONYL FORTE

METHYCLOTHIAZIDE 5 MG. WITH DESERPIDINE 0.5 MG.

	Minimum	Usual	Intermediate	Maximum
DAILY DOSAGE RANGE	2.5 mg. methyclothiazide 0.125 mg. deserpidine	5 mg. methyclothiazide 0.25 mg. deserpidine	7.5 mg. methyclothiazide 0.375 mg. deserpidine	10 mg. methyclothiazide 0.5 mg. deserpidine
DAILY DOSAGE RANGE	2.5 mg. methyclothiazide 0.25 mg. deserpidine	5 mg. methyclothiazide 0.5 mg. deserpidine	7.5 mg. methyclothiazide 0.75 mg. deserpidine	10 mg. methyclothiazide 1 mg. deserpidine

See Brief Summary on final page of advertisement.

707075-R

Eutonyl affords a different kind of basic therapy for moderate to severe cases

ABBOTT

Effect tied to reduced peripheral vascular resistance; no central depressant action

Eutonyl is a unique nonhydrazine agent. It is reported to act by reducing peripheral vascular resistance.[1,2]

In clinical trials, significant reductions in mean blood pressure were seen in 84% of patients studied—all were moderate to severe cases. Eutonyl lowers diastolic in proportion to systolic, and in about half of the cases studied, reductions in the sitting and recumbent positions were nearly as great as in the standing position.

Most important: There is no central depressant action. In fact, some patients reported an *increased* sense of well being.

Here, then, is a highly effective *basic treatment* for moderate to severe cases—and one that will not hamper your patient with lethargy or drowsiness while on treatment.

Once a day, every day

EUTONYL®
PARGYLINE HYDROCHLORIDE



DAILY DOSAGE RANGE	Minimum	Usual starting	Intermediate	Maximum
	10 mg. tablet	25 mg. tablet	50 mg. tablet or as needed	200 mg.

1. Brest, A. N., et al., Cardiac and Renal Hemodynamic Response to Pargyline, Ann. N. Y. Acad. Sci., 107-1016, 1963.
2. Winsor, T., Pargyline Hydrochloride, Hypertension, Urinary Tryptamine, and Vascular Reflexes, Geriatrics, 19:598, Aug., 1964.

See Brief Summary on final page of advertisement.

Eutron adds thiazide for enhanced therapy with milder side effects

Only a 7/4 mm. span between standing and recumbent pressures in clinical trials—reduced chance of orthostatic hypotension

The combining of Eutonyl and Enduron in Eutron permits a significantly greater antihypertensive effect than with either agent used alone. This in turn may allow therapeutic success with lesser dosage—and correspondingly milder side effects.

A significant finding in clinical trials was the drug's action in lowering blood pressure to *nearly equal levels in all body positions*. Total average spread between standing and recumbent readings (after treatment) was only 7/4 mm. Hg.

Thus, in your moderate to severe cases, Eutron affords a usually smooth course of therapy, often with reduced likelihood of orthostatic effects. (The usual precautions against rising suddenly, of course, will always apply.) And, because of the thiazide component, Eutron may be used in the presence of congestive heart failure.





Once a day, every day

EUTRON™

PARGYLINE HYDROCHLORIDE 25 MG.
WITH METHYCLOTHIAZIDE 5 MG.

	Minimum	Usual starting	Intermediate	Maximum
DAILY DOSAGE RANGE	12.5 mg. pargyline hydrochloride and 2.5 mg. methyclothiazide	25 mg. pargyline hydrochloride and 5 mg. methyclothiazide	37.5 mg. pargyline hydrochloride and 7.5 mg. methyclothiazide	50 mg. pargyline hydrochloride and 10 mg. methyclothiazide

See Brief Summary on final page of advertisement.

TM—Trademark

707075-R

ENDURON® | ENDURONYL®

METHYCLOTHIAZIDE

Each tablet contains
Methyclothiazide 5 mg. with
Deserpidine 0.25 mg. or 0.5 mg.

Indications: Enduron is used to control edema and mild to moderate hypertension; also used with other drugs for hypertension. Enduronyl is used in mild to moderately severe hypertension; when used with Enduronyl, more potent agents can be given at reduced dosage to minimize undesirable side effects.

Contraindications: Neither Enduron nor Enduronyl should be used in severe renal disease (except nephrosis) or shutdown; in severe hepatic disease or impending hepatic coma; in patients sensitive to thiazides. Hepatic coma has been reported as a result of hypokalemia in patients receiving thiazides.

Enduronyl is contraindicated in patients with severe mental depression and suicidal tendencies, active peptic ulcer, or ulcerative colitis.

Warnings: Consider possible sensitivity reactions in patients with a history of allergy or asthma. If added potassium intake is indicated, dietary supplementation is recommended. Enteric-coated potassium tablets should be reserved for cautious use only when adequate dietary supplementation is not practical because those tablets may induce serious or fatal small bowel lesions consisting of stenosis with or without ulceration. These small bowel lesions have caused obstruction, hemorrhage and perforation frequently requiring surgery. Medication should be discontinued immediately if abdominal pain, distension, nausea, vomiting or GI bleeding occurs.

Precautions: Use thiazides with caution in severe renal dysfunction, impaired hepatic function, or progressive liver disease. In surgical patients, thiazides may reduce the response to vasopressors and increase the response to tubocurarine. Use thiazides with caution in pregnancy (bone marrow depression, thrombocytopenia, or altered carbohydrate metabolism have been reported in certain newborn infants). Also reported have been: blood dyscrasias including thrombocytopenia with purpura, agranulocytosis and aplastic anemia; elevations of BUN, serum uric acid, or blood sugar. Symptomatic gout may be induced. Antihypertensive response may be enhanced following sympathectomy.

Use Enduronyl with caution in patients with a history of peptic ulcer, as rauwolfias may increase gastric secretion. Discontinue at the first sign of mental depression. Rauwolfia alkaloids may increase hypotensive effects of surgery or anesthesia, and should be discontinued two weeks prior. They also lower the convulsive threshold and shorten seizure latency. In epilepsy, dosage adjustment of anticonvulsant medication may be necessary. Alcohol, barbiturates, or narcotics may potentiate action of deserpidine.

Adverse Reactions: During intensive or prolonged therapy, guard against hypochloremic alkalosis and hypokalemia (especially the latter if patient is on digitalis). All patients should be observed for signs of hyponatremia ("low-salt" syndrome). Reported thiazide reactions include: anorexia, nausea, vomiting, diarrhea, headache, skin rash, dizziness, paresthesia, weakness, photosensitivity, jaundice, and pancreatitis.

Reported rauwolfia reactions include: nasal stuffiness, nausea, weight gain, diarrhea, aggravation of peptic ulcer, epistaxis, skin eruption, and reduction of libido and potency. Excessive drowsiness, fatigue, weakness, and nightmares may signal early signs of mental depression.

EUTONYL® | EUTRON™

PARGYLINE HYDROCHLORIDE

Each tablet contains
Pargyline Hydrochloride 25 mg.
with Methyclothiazide 5 mg.

Indications: For treatment of patients with moderate to severe hypertension, especially those with severe diastolic hypertension. Not recommended for patients with mild or labile hypertension amenable to therapy with sedatives and/or thiazide diuretics alone. It is desirable to establish the dosage of Eutron by administering component drugs separately.

Contraindications: Pheochromocytoma, advanced renal disease, increasing renal dysfunction, paranoid schizophrenia and hyperthyroidism. Hepatic coma has been reported as consequence of hypokalemia with thiazide therapy. Until further experience is gained not recommended for patients with malignant hypertension, children under 12, or pregnant patients.

Concomitant use of the following is contraindicated: other monoamine oxidase inhibitors; parenteral forms of reserpine or guanethidine; sympathomimetic drugs; foods high in tyramine such as cheese; imipramine and amitriptyline, or similar antidepressants; methyldopa. 2 week interval should separate therapy and use of these agents.

Methyclothiazide is contraindicated in patients with known sensitivity to thiazides.

Warnings: Pargyline hydrochloride is a monoamine oxidase inhibitor. Warn patients against eating cheese, and using alcohol, proprietary drugs or other medication without the knowledge of the physician. When indicated, alcohol, narcotics (meperidine should be avoided), antihistamines, barbiturates, chloral hydrate, and other hypnotics, sedatives, tranquilizers, or caffeine, may be used cautiously in reduced dosage. In emergency surgery ¼ to ⅓ the usual dose of narcotics, analgesics, and other premedications should be used avoiding parenteral administration where possible. Carefully adjust dose of anesthetics to response of patient. Withdraw pargyline two weeks before elective surgery.

Warn patients about the possibility of postural hypotension. Those with angina or coronary artery disease should not increase physical activity with an improvement in well being. Pargyline may lower blood sugar.

Avoid use of enteric-coated potassium tablets, as these may induce serious or fatal small-bowel lesions consisting of stenosis with or without ulceration. These small-bowel lesions have caused obstruction, hemorrhage and perforation frequently requiring surgery. Medication should be discontinued immediately if abdominal pain, distension, nausea, vomiting or GI bleeding occurs. These products contain no added potassium salts and if added potassium intake is desired, dietary supplementation is recommended. Coated potassium tablets should be reserved for cautious use when adequate dietary supplementation is impractical. In patients with a history of allergy or asthma the possibility of sensitivity reactions should be considered.

Precautions: Measure blood pressure while patient is standing to determine antihypertensive effect. Use with caution in hyperactive or hyperexcitable persons. Such persons may show increased restlessness and agitation. Withdraw drug during acute febrile illness. Watch patients with impaired renal function for increasing drug effects or elevation of BUN and other evidence of progressive renal failure; withdraw drug if such alterations persist and progress. Use with caution in patients with liver disease. As with all new drugs, complete blood counts, urinalyses, and liver function tests should be performed periodically. With prolonged therapy, examine patients for change in color perception, visual fields and fundi. Also reported have been: blood dyscrasias including thrombocytopenia with purpura, agranulocytosis and aplastic anemia; elevations of BUN, serum uric acid, or blood sugar. Symptomatic gout may be induced. In surgical patients thiazides may reduce response to vasopressors and increase response to tubocurarine.

Adverse Reactions: Pargyline may be associated with orthostatic hypotension. Mild constipation, slight edema, dry mouth, sweating, increased appetite, arthralgia, nausea and vomiting, headache, insomnia, difficulty in micturition, nightmares, impotence, delayed ejaculation, rash, and purpura have been encountered with pargyline. Hyperexcitability, increased neuromuscular activity (muscle twitching) and other extrapyramidal symptoms have been reported in a few patients with reduced cardiac reserve.

During intensive or prolonged therapy, guard against hypochloremic alkalosis and hypokalemia (especially the latter if patient is on digitalis). Observe all patients for signs of hyponatremia ("low salt" syndrome).

Reported thiazide reactions also include anorexia, nausea, vomiting, diarrhea, headache, dizziness, paresthesia, weakness, skin rash, photosensitivity, jaundice, and pancreatitis. Nocturia has been observed with the combination.

709075R

ABBOTT

TM-Trademark.

Association News

Council and Committee Meetings

Editor's Note: The following are summaries of recent council and committee meetings. Final determinations on all actions or recommendations are made by the Association's House of Delegates at the Annual Meeting.

T.M.

Subcommittee on Venomous Snakebite met May 11 and agreed on a need for standardization of snake bite therapy, further agreeing that crosshatch incisions and freezing should be discouraged. It was decided that the subcommittee report should be submitted to the Board of Governors with later consideration being given to adapting the report for publication in the Journal.

Committee on Mental Retardation met jointly with counterpart committees of the Florida Pediatric Society and the Florida Association for Retarded Children May 13 and recommended that the FMA urge each county medical society to appoint a committee or an individual physician responsible for activities in the area of mental retardation and that a committee be appointed to explore the possibility of a mental retardation department in the Journal.

Florida Committee on Rural Health, of which the FMA is a member organization, met May 25 and agreed to adopt a program of improving emergency medical care in Florida's rural areas. Each member organization was requested to give approval and report its progress of implementation regularly.

Council on Voluntary Health Agencies met May 27 and proposed a directory of Florida health services cosponsored by the FMA and possibly financed through the Florida Medical Foundation or the State Board of Health. Other actions included agreement to write the Governor's Steering Committee on Health urging that the state voluntary health agencies and the Florida Voluntary Health Association be represented in any statewide advisory group for health planning under PL 89-947 and to ascertain in writing the relationship between United Health Foundations-United Funds and the Florida Medical Foundation. Pending applications for official FMA recognition of several voluntary health agencies were reviewed.

Committee on Scientific Assemblies met July 29 and considered the format and content of the 1968 Annual Meeting, deciding that one panel discussion comprise the Friday morning session with the Friday afternoon session to be devoted to presentation of papers by Florida physicians. Subjects and speakers for the scientific program were considered.

Florida Joint Council on Health of the Aging, of which the FMA is a member organization, met August 29 and discussed the activities of member organizations. A decision was made to invite representatives from nursing education, the State Board of Nursing and the Florida Legislative Council to the next meeting to consider the problem of the shortage of nursing and other ancillary health personnel.

Council on Specialty Medicine met September 9 and endorsed the revised Relative Value Studies with the provision that the Council recommends to the Board of Governors that the FMA commence a continuing study aimed at annual revisions. Members of the Council were asked to review the Medical Practice Act to determine if revision was necessary. A request of the Florida Psychiatric Society for assistance from the Council was referred to the Board of Governors for advice and recommendations.

FMA Investment Plan Available to Members

FMA members' attention is called to the availability of the Florida Medical Association Investment Plan. According to Secretary-Treasurer Dr. Floyd K. Hurt, the Plan has been carefully designed for the investment needs of physicians. It offers a choice of investment in a no-load balanced fund with no sales charge (Loomis-Sayles Mutual Fund) or in an aggressive common stock fund (Loomis-Sayles Capital Development Fund) plus pension life insurance with guaranteed retirement benefits through Pan American Life Insurance Company. Attention is further directed to this month's President's Page appearing elsewhere in this issue. Details and applications may be obtained by writing Florida Medical Association Investment Plan, P.O. Box 2297, Jacksonville, Florida 32203.

See President's Page, page 1031

Report of Ad Hoc Committee on Resolution 67-22

Editor's Note: This report has been approved by the Board of Governors and will be presented to the House of Delegates in May 1968 for final action.

T.M.

Careful consideration has been given to Resolution 67-22 requesting that a study be made of Blue Cross to Blue Shield and suggesting that there exists "an increasing degree of federal control of Blue Cross of Florida policies and actions."

See editorial comment, page 1071

There is no question but what there has been a tremendous effect on both Blue Shield of Florida and Blue Cross of Florida by the advent of Medicare and by their being selected by request respectively of the Florida Medical Association and the Florida Hospital Association to act as fiscal agents for the Medicare program. This has resulted in a 350% increase in the number of employees of these two organizations, in the necessity of more than doubling the office space and in quadrupling the amount of money handled by the Blues. Despite this fact there is no indication that there is a single member of the Blue Shield Board of Directors who feels there has been *any* degree of federal control exercised over Blue Shield or Blue Shield policies. Nor has there been any evidence to substantiate the undocumented allegation that there is at the present time, or has been in the past, any degree of federal control over Blue Cross of Florida. In the opinion of this committee such an allegation is without basis in fact.

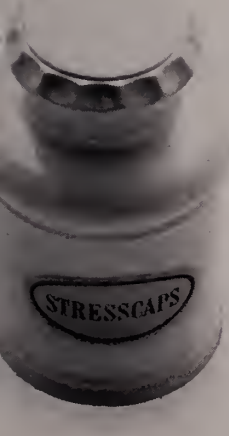
Insofar as the relationship of Blue Cross and Blue Shield is concerned, we believe it can be said emphatically that it has never been better and there is every indication to suggest that this relationship will become closer in the future. The parent organization of Blue Cross is the Florida Hospital Association, just as the parent organization of Blue Shield is the Florida Medical Association. Just as differences arise between hospital medical staffs and hospital administrations, differences arise between Blue Cross and Blue Shield. But just as surely as such differences can, and usually are, resolved by reasonable people through proper dialogue, so can, and are, Blue Cross-Blue Shield differences resolved.

At no time in the history of Blue Cross have the doctors of Florida been in a more favorable position to get a sympathetic hearing of their views than at the present time. It is worth noting that the newly elected president of Blue Cross



in chronic illness

B and C vitamins are part of therapy: An imbalance of water-soluble vitamins and chronic illness often go hand in hand. STRESSCAPS capsules, containing therapeutic quantities of vitamins B and C, are formulated to meet the increased metabolic demands of patients with physiologic stress. In chronic illness, as with many stress conditions, STRESSCAPS vitamins are therapy.



Stresscaps®

Stress Formula Vitamins Lederle

FOR PROFESSIONAL
RECOMMENDATION ONLY

Each capsule contains:

Vitamin B_1 (as Thiamine Mononitrate)	10 mg
Vitamin B_2 (Riboflavin)	10 mg
Vitamin B_6 (Pyridoxine HCl)	2 mg
Vitamin B_{12} Crystalline	4 mcgm
Vitamin C (Ascorbic Acid)	300 mg
Niacinamide	100 mg
Calcium Pantothenate	20 mg

Recommended intake: Adults, 1 capsule daily, for the treatment of vitamin deficiencies. Supplied in decorative "reminder" jars of 30 and 100; bottles of 500.

LEDERLE LABORATORIES, A Division of American Cyanamid Company, Pearl River, New York

Lederle

628-6—3614

is Mr. Frank Kelly, a member of the Blue Cross Board for over 20 years and the legal counsel of the Dade County Medical Association for over 20 years. Mr. Kelly is certainly very aware of the problems that face doctors through his association with the largest county medical society in Florida. The newly elected president of Blue Shield is Dr. Warren Quillian, a past president of DCMA, and the Florida Medical Association, and a member of the Blue Shield Board for three years, as well as of the Blue Cross Board for the past two years. Dr. Quillian and Mr. Kelly are long time personal friends, who are well aware of the necessity of full understanding and cooperation between Blue Shield and Blue Cross and early in their presidencies they instituted actions to accomplish this aim. Most notable of these was the Joint Blue Shield-Blue Cross Informational Meeting held on July 20-22, 1967, at which the members of the Boards of both corporations participated and exchanged ideas. The consensus of those present was that this meeting was most successful in reducing areas of friction between the two Boards and in increasing mutual understanding.

As further evidence of the favorable position of the Florida Medical Association with regard to Blue Cross at the present time, it should be pointed out that for the first time in Blue Cross history a doctor, Dr. Henry Babers, has been appointed chairman of the Blue Cross New Contracts Committee. Since Dr. Babers is also a member of the Blue Shield New Contracts Committee, it should be possible to anticipate and eliminate areas of conflict in new contracts before they are issued rather than afterwards. In this dual position he should be in a most favorable position to help to reconcile any differences which are to be found in existing contracts.

And, finally, it is noteworthy that sitting on the present Blue Cross Board are five members of the Florida Medical Association; two of whom are past presidents of the Association; one, a past speaker of the House of Delegates and the president of the Florida State Board of Health; and another, a past chairman of the Committee of 17 and the Fee Schedule Committee and a past member of the Board of Governors.

In the past difficult year with all the problems incidental to the institution of the Medicare program, the Blue Cross Board has agreed without exception to changes in procedures for handling claims and in contract modifications as requested by the Blue Shield Board. The single area of major disagreement was Blue Cross' decision to terminate the policies of all of its subscribers 65 years of age or older. While the Blue Shield Board disagreed with this action it recognized that the Medicare law is mandatory in its application to hospitals and is optional with regard to doctors' fees, which fact presented the Blue Cross Board with an entirely different problem from that facing the Blue Shield Board.

In summary, it is the opinion of this Committee that:

1. The suggestion that the federal government is exercising an undue and unsalutory effect on Blue Cross of Florida is unfounded.

2. The relationship existing between the Boards of Blue Cross and Blue Shield of Florida is warmer, friendlier and more understanding than it ever has been before and there is every evidence to suggest that it will become more so.

3. The doctors of Florida are well and adequately represented by the five physicians on the Blue Cross Board, who are accorded a fair and sympathetic hearing by the nonmedical members of the Board.

Robert E. Zellner, M.D.
Chairman

AMA Opposes Blue Shield Schedules As Basis for Medicare Physician Payment

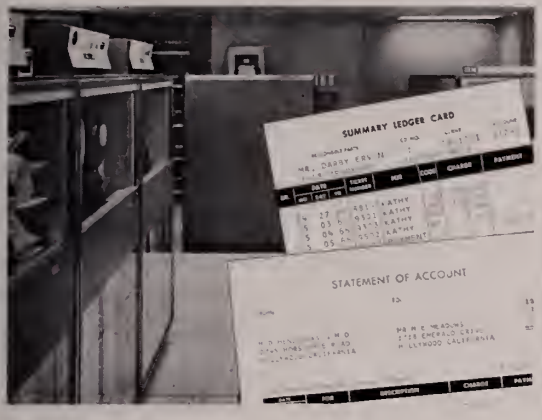
The American Medical Association strongly opposed a suggestion that doctor's fees under Medicare be based on Blue Shield schedules.

The suggestion was made to AMA officials while they were testifying before the Senate Finance Committee on the House-approved social security bill which includes amendments to the Medicare and Medicaid programs. Dr. Samuel R. Sherman, San Francisco, chairman of the AMA's Council on Legislative Activities, said there would

ASSOCIATED MANAGEMENT INC.

FIRST FEDERAL BUILDING
8340 N.E. 2ND AVENUE
MIAMI, FLORIDA 33138

Accounts receivable management system designed specifically for doctors



This system offers doctors the advantage of computer techniques for accounts receivable management with no investment in equipment. All that's required from the doctor is a daily report voucher on each patient. From this, AMS furnishes a whole series of regular reports and analyses plus the preparation of each patient's monthly statement. The cost is usually far less than doing your own bookkeeping.

We are part of a National Concern serving Doctors for over 6 years.

☐ Please send me your Accounts Receivable Management Brochure.

☐ Please have one of your consultants call me for an appointment.

Name

Address

City Phone

In Obesity, anorectic action with fewer unwanted side effects



CYDRIL®
(levamfetamine succinate TUTAG)



Cydril at 2 p.m. Appetite control at 6 Sleep at 10

Action and Uses: Cydril (levamfetamine succinate) is a chemopharmaceutical approach to aid the obstinately obese. Cydril (levamfetamine succinate) provides the appetite depressant action of amphetamines but exhibits fewer unwanted side reactions.

Dosage: Adults and 'teenagers', one (1) Cydril (levamfetamine succinate) Granucap* daily.

Side Effects: Occasionally cardiovascular and gastrointestinal reactions may produce dry mouth, metallic taste, anorexia, nausea, diarrhea, headache, chilliness, pallor or flushing, sweating, diuresis, and arrhythmias.

Contraindications: Cydril (levamfetamine succinate) should not be used in the presence of severe hypertension, angina pectoris, hyperthyroidism, and Raynaud's disease.

*Granucap is the Tutag brand of sustained release capsule manufactured to release the contents over a period of approximately 6 to 10 hours.

Caution: Federal law prohibits dispensing without prescription.

Full product information available on request or see page 1122 in your 1967 PDR.

For more about CYDRIL and the Cydril Family of Products ask the Man from Tutag (or your colleagues)

S.J. TUTAG & CO. ETHICAL PHARMACEUTICALS
DETROIT, MICHIGAN 48234

be heavy opposition from the medical profession to any change from the present usual-and-customary fees.

Dr. Milford O. Rouse, president of the AMA, gave general approval to the bill passed by the House which, he pointed out, incorporated a number of changes recommended by the AMA. He said further substantive changes better could await the knowledge that one or two more years of experience would bring. He urged, however, that consideration then be given to major changes in Medicare Plan B which covers physicians' services.

"We believe it is possible for the Congress, the medical profession and others interested in the subject to develop a new mechanism for delivering medical care to people over 65 that would be consistent with existing private sector mechanisms," Dr. Rouse said.

". . . the Congress realizes it has an open-end program with rising and perhaps uncontrollable costs. We believe that it is possible, and would be eminently practical, to devise another approach that could solve problems which beset Part B. One possibility, for example, might be to substitute for the Part B program a subsidy to all eligible persons, to be used for the purchase of private health insurance. Such an approach could have many advantages.

"The eligible over-65 patient would have a qualified private insurance program of his choice, at no greater expense than he has under the Part B Medicare program; carriers would have a greater responsibility for their own performance with an opportunity to exercise initiative; the physician would continue to deal with his over-65 patient in every respect in the same way as he did before the patient's birthday; and the Congress would have a program with defined costs, and one which would offer the nation a comparison of mechanisms in use to meet the problems of financing health care of the elderly."

AMA Reaffirms Support of All Nursing Education Programs

The American Medical Association's policy-making House of Delegates has reaffirmed the Association's support of all forms of nursing education programs.

At its June 1967 biannual session in Atlantic City, the House adopted the following statement on nursing education:

Whereas, The American Medical Association is on record to "continue its support of *all* current nationally approved educational programs for nurses;" and

Whereas, The national trend which is supported by the professional nurses' associations appears to be the gradual phasing out of the diploma schools of nursing and the transfer of nursing education to collegiate institutions; and

Whereas, 70 per cent of nursing care at the present time is rendered by graduates of diploma schools with the demand for such nurses continuing to exceed the supply; and

Whereas, There is general professional agreement on the need for inclusion of nursing education in community health planning with provision for greater use of in-hospital training as well as training in collegiate institutions, therefore, be it

RESOLVED, That the American Medical Association reaffirms its support of all forms of nursing education including baccalaureate, diploma, associate and practical nurse education programs; and be it further

RESOLVED, That those hospitals that conduct diploma schools of nursing be commended for the great contribution being made by these institutions to the health needs of the nation; and be it further

RESOLVED, That such hospitals be urged to continue their schools and increase enrollment while allowing the individual to choose the kind of nursing education he or she desires; and be it further

RESOLVED, That the American Medical Association take appropriate action in consultation with professional nurses' associations and the American Hospital Association to encourage increasing enrollment in diploma schools and at the same time improve educational standards.

Confidential and Privileged Communications

This legal opinion regarding confidential and privileged communications was prepared by Harry T. Gray, Esq. of the law firm Marks, Gray, Yates, Conroy & Gibbs of Jacksonville, FMA legal counsel.

T.M.

With regard to the question of disclosure by a physician of information obtained from a patient:

In most states, information obtained by a priest or an attorney from a person is not only confidential but it is privileged. This means that neither the priest nor the lawyer can disclose the information obtained without permission from the person giving the information. This is not the situation with reference to physicians in Florida. In Florida, except as to psychiatrists, information obtained by a doctor from a patient, while confidential, is not privileged. This means the doctor can be required to disclose the information under appropriate judicial procedures. These could be under a subpoena requesting the doctor to appear to testify under oath, by deposition, before an administrative body, or in a Court of law, civil or criminal.

Psychiatrists are in a different status. In 1965, the Florida legislature passed §90.242 which in substance prevents a psychiatrist from disclosing communications between the patient and psychiatrist, or between members of the patient's family and the psychiatrist, or records relating to diagnosis or treatment of the patient's mental condition.

Another statute, §458.16, provides in substance that any doctor making a physical or mental examination or administering treatment shall upon request of the person treated or his guardian or personal representative furnish copies of reports of examinations or treatment but these are furnished only upon written authorization.

Other than these two statutes, we find nothing in the Florida law that has abolished the physician's duty to maintain his confidential relationship with the patient and not disclose information concerning the patient until legally required to do so as is said in Doctor and Patient, page 273:

> "Since the legal consequences of an unwarranted release of confidential information are uncertain and since the consequences may be serious, it is necessary that a physician be most cautious when divulging any information about a patient. Although there are exceptions to the proposition that all confidential information acquired from a patient should be kept secret, the basic rule to remember is that confidential information should not be revealed without obtaining the patient's consent unless state law requires the physician to report the information."

A Florida case, Morrison v. Malmquist, SC 62 So. 2d, 415, indirectly confirms what we have said: That a physician can be required to disclose confidentially obtained information from his patient in an appropriate judicial proceeding.

Harry T. Gray

AMERICAN MEDICAL ASSOCIATION

a federation of 54 constituent medical associations and 1936 component medical societies.

Dear Fellow Physician:

These are significant times for all American citizens and for American Medicine. This is a cordial and earnest invitation for you to join us in a re-evaluation of our resources, abilities and opportunities and then with courage and enthusiasm proceed to utilize and develop them.

This will involve us and you individually as participating citizens and faithful physicians, and collectively as more diligent and effective workers in our county medical societies, state associations, specialty groups and the American Medical Association. To this joint effort we invite your enthusiastic and wholehearted cooperation.

The greatest need is probably for more efficient, fruitful communication. We urge you to take a few minutes each month to read the President's Page in your county medical bulletin, state medical journal, and first issue each month of JAMA. We promise you a brief, worthwhile message every month, emphasizing and referring you to things that will interest you. An efficient review of each copy of The AMA News will keep you posted on general developments.

You will enjoy and profit from your membership in medical groups in direct proportion to your investment of time in them. We will anticipate seeing you regularly at our medical meetings.

The public relations of Medicine depends on how you and your office aides serve your patients, and how you perform as a citizen.

We will welcome your suggestions at all times, and we thank you sincerely for your cooperation.

Cordially,

Milford O. Rouse, M.D.

Milford O. Rouse, M. D., President
American Medical Association

W. Dean Steward

W. Dean Steward, M.D., President
Florida Medical Association



DUAL PROBLEM IN PEPTIC ULCER

Relief of hyperacidity is still a primary goal in the treatment of peptic ulcer. And antacids are the most widely used means of achieving this relief. But antacids alone cannot influence the distention and bloating which so often add to ulcer distress.

THIS IS WHY MYLANTA® PROVIDES:

the two most widely used antacids—magnesium and aluminum hydroxides—to help secure rapid acid neutralization with little chance of laxation or constipation;

PLUS

the defoaming action of simethicone—to help relieve the painful gas symptoms which often accompany peptic ulcer.

Mylanta®

antacid therapy plus an added benefit

nonfatiguing flavor/smooth pleasant texture; both assure patient cooperation during long-term therapy.

Stuart Division of / ATLAS CHEMICAL INDUSTRIES, INC. / Pasadena, Calif.



when he just can't sleep

Tuinal®

One-Half Sodium Amobarbital and
One-Half Sodium Secobarbital
supplied in ¾, 1½, and 3-grain Pulvules®



Tuinal helps wakeful patients fall asleep fast, stay asleep all night.

Indications: Tuinal is indicated for prompt and moderately long-acting hypnosis. It is not suitable for continuous daytime sedation.

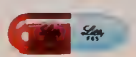
Contraindications: Barbiturates should not be administered to anyone with a history of porphyria, nor should they be given in the presence of uncontrolled pain, because excitement may result.

Warning: May be habit-forming.

Precautions: Tuinal should be used cautiously in patients with decreased liver function, since prolongation of effect may occur.

Adverse Reactions: Idiosyncrasy, such as excitement, hangover, or pain, may appear. Hypersensitivity reactions occur in some patients, especially in those with asthma, urticaria, or angioneurotic edema.

Overdosage: C.N.S. depression. Symptoms—Depression of respiration and of superficial and deep reflexes, slight constriction of the pupils (in severe poisoning, dilation), decreased urine formation, lowered body temperature, coma. Treatment—Symptomatic and supportive (gastric lavage; intravenous fluids; maintenance of blood pressure, body temperature, and adequate respiration). Dialysis may speed removal of barbiturates from body fluids.



Dosage: 50-200 mg. (¾-3 grains) at bedtime.

[031767]

Additional information available to physicians upon request.
Eli Lilly and Company • Indianapolis, Indiana 46206

700955

Lilly

Need a head mirror?



Ask your lab supply man!

Need a placebo?



Phone your pharmacist!

Need optical services?

GUILD Rx OPTICIANS ®

Call on an expert —

YOUR GUILD OPTICIAN!

Your local Guild Optician has the special skills and experience with which to properly serve your patients in the area of optical services. He is, in short, an expert, and here's why:

The Rx you write must be accurately filled and properly adjusted for optimum results. *Your Guild Optician is highly skilled at both.*

Patients with special problems demanding frequent adjustment require special handling — time, patience and infinite care must be devoted to these cases. *Your Guild Optician has these qualities in full measure.*

Your patients must be able to count on the optician to routinely handle any problem of after-service and repair for the life of the glasses they wear. *Your Guild Optician is always available with his skills to help your patients.*

In serving you, the Guild Optician also has a stake in the welfare of your patients; depend on his expert services and experience to be sure your patients are getting the best possible results from the prescriptions you write! *Guild of Prescription Opticians of Florida.*

USING GUILD SKILLS AND EXPERIENCE TO SERVE YOUR PATIENTS

Gebauer's Ethyl Chloride stops creeping eruption cold





highly magnified drawing of the Ancylostoma Braziliense

Creeping eruption is ugly, uncomfortable, and persistent. And, in Florida, it is seen with considerable frequency.

Creeping eruption is caused by the larvae of the dog and cat hookworm, *Ancylostoma Braziliense*. The larvae of this parasite burrow between the superficial layers of the skin, causing much discomfort and characteristic angry eruptions.

Happily, Gebauer Ethyl Chloride sprayed on the affected area for 30 seconds to one minute will usually kill the offending larvae. In difficult cases, it may be necessary to spray for a period of up to two minutes. Improvement and cure generally follow a comparatively few applications.

Next time you treat creeping eruption, treat it with Gebauer Ethyl Chloride. Also highly effective as a topical anesthetic for minor surgery, as in removal of splinters, incision of boils and whitlows, and to alleviate needle pain. May be used for relief of pain such as first and second degree burns, bee stings, sprains and muscle spasm.

GEBAUER PRODUCTS AVAILABLE AT

CORAL GABLES: Surgical Equipment Co. JACKSONVILLE: Central Medical & Surgical Supply • Hermax Corporation • Medical Supply Co. of Jacksonville • Surgical Supply Co. MIAMI: Amedic Surgical Co. • Florida Physicians Supply • Medical Supply Co. ORLANDO: Anderson Surgical Supply Co. • Medical Supply Co. ST. PETERSBURG: Anderson Surgical Supply Co. SARASOTA: Anderson Surgical Supply Co. TALLAHASSEE: Southeastern Surgical Supply Co. TAMPA: Anderson Surgical Supply Co. • Medical Supply Co. • Southern Surgical Supply Co. • Surgical Equipment Co. of Florida. WEST PALM BEACH: Medical Associates Corp. • Medical Supply Co.

OR YOUR LOCAL PHARMACY

Gebauer's

GEBAUER CHEMICAL COMPANY

9410 St. Catherine Ave. • Cleveland, Ohio 44104

DIARRHEA



CANTIL®
(mepenzolate bromide)

LAKESIDE

Diarrhea, one of the most vexing symptoms of common G. I. disorders can often be curbed with Cantil (mepenzolate bromide), bringing welcome relief to the harassed patient. Relatively specific for the hyperactive colon, it helps reduce diarrhea, pain and spasm with minimal effect on other viscera. Cantil (mepenzolate bromide) is indicated whenever these symptoms are associated with irritable colon, gastroenteritis, diverticulitis, and mild to moderate ulcerative colitis.

It is an anticholinergic drug without narcotic properties. Side effects are usually mild.

IN BRIEF: One or two tablets three times a day and one or two at bedtime usually provide prompt relief. Cantil with Phenobarbital may be prescribed if sedation is required.

Dryness of the mouth, blurring of vision, constipation, nausea, vomiting, bloating and dizziness may occur but are usually mild and transitory. Urinary retention is rare. Caution should be observed in prostatic hypertrophy — withhold in glaucoma. Contraindicated in patients sensitive to phenobarbital and/or Cantil (mepenzolate bromide); in toxic megacolon, obstruction of G. I. or G. U. tract.

SUPPLIED: CANTIL (mepenzolate bromide) — 25 mg. per scored tablet. Bottles of 100 and 250. CANTIL with PHENOBARBITAL — containing in each scored tablet 16 mg. phenobarbital (warning: may be habit forming) and 25 mg. mepenzolate bromide. Bottles of 100 and 250.

LAKESIDE LABORATORIES, INC., Milwaukee, Wisconsin 53201



50 Years Ago in the Journal

November 1917

The November 1917 issue of the Journal contained the following three scientific papers: "Tuberculosis and the Problem it Presents," by R. H. McGinnis, M.D., of Jacksonville; "Some Practical Suggestions Concerning Electricity and Vibration in Gastrointestinal Affections," by George M. Niles, M.D., Atlanta, Ga., and "Report of a Case of Maculo-Anaesthetic Leprosy," by J. L. Kirby-Smith, M.D., of Jacksonville.

In his paper which earlier had been read before a conference of anti-tuberculosis and Red Cross workers, Dr. McGinnis described the disease, noting with encouragement that its mortality had been reduced 25 per cent in 12 years. He expressed the opinion that if control of the focus of infection were accomplished, the problem of tuberculosis would be solved. Observing that patients recover ". . . anywhere and everywhere, for it matters less where than how they live," the author (apparently regretfully) concluded with the fact that there was as yet no "accredited" specific for tuberculosis.

Dr. Niles, in beginning his paper, stated forthrightly that his experience had demonstrated that electricity "in various forms" had "actual and tangible" effects upon the secretory and motor functions of the stomach and also on its "sensibility." Admitting the existence of controversy over these effects, Dr. Niles went on to detail his use of several internal and external electric therapy methods in treating a variety of gastric ailments.

Dr. Kirby-Smith, a prolific writer in the field of dermatology, reported on a case of leprosy he had seen, introducing the paper with the observation that while leprosy undoubtedly was uncommon in Florida, from time to time nevertheless cases were seen. The author stated that five cases he had treated originated in Key West and a sixth in Duval County.

In the issue, the Journal printed an honor roll of physicians who had volunteered for World War I military service, boasting editorially that Florida was "well at the head of the list" of states in ratio of physicians to medical population having offered their services. It appealed, however, for more medical officers because of increasing needs and the fact that the state was still short of its quota established by the War Department.

Due to financial problems for the Journal brought on by more and more FMA members entering the service, it was reported that the Duval County Medical Society voted to remit to the state association $1.50 for every member absent on military duty, provided the FMA would accept that amount in lieu of the three dollar annual state dues of the individual member and apply the amount toward maintenance of the Journal. Other county societies were urged to follow the precedent.

A full page advertisement for Tulane University College of Medicine stated that beginning Jan. 1, 1918, all students entering the freshman class would be required to present credits for two years of college work, which must include ". . . Biology, Chemistry and Physics, with their laboratories, and one year in German or French." The ad also asserted that women were admitted to all schools on the same terms as men.

Dear Doctor:

Wouldn't you like your patients to learn more about the contributions made by the world of medicine to their welfare? So that they can better appreciate the efforts of the health team to keep them in good health?

To tell the stories of medical and pharmaceutical advances to people throughout the country, the Pharmaceutical Manufacturers Association is sponsoring a unique "magazine within a magazine." It is called *Medicines and your family's health* and the first issue appears in the November *Reader's Digest.*

We would like to send you 50 free reprint *Medicines and your family's health* for use in y reception room. Your patients will find the arti in this issue factual, educational and of immed personal interest.

Just fill out the coupon below and send it to

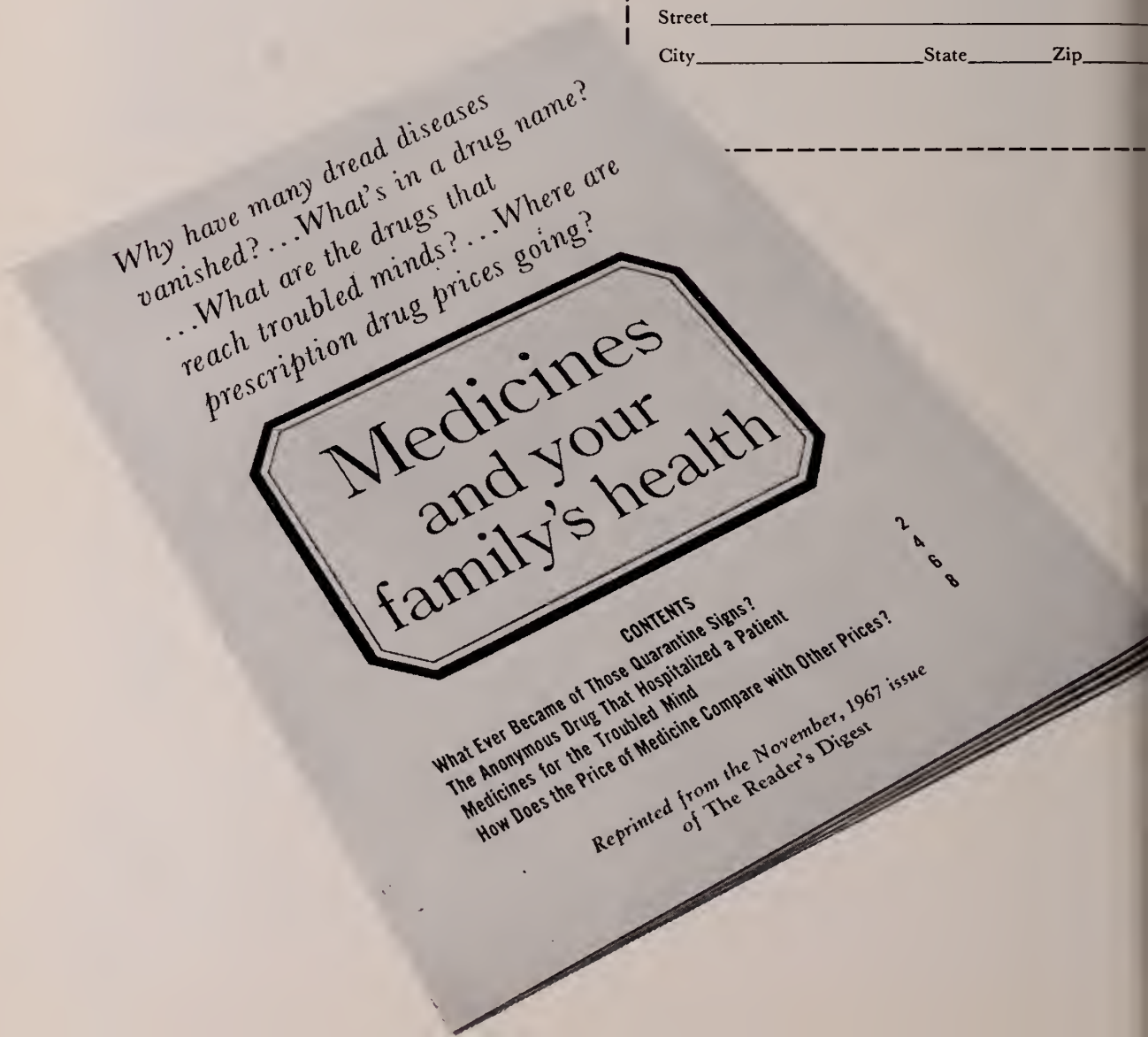
Order Desk
Pharmaceutical Manufacturers Association
1155 Fifteenth St., N.W.
Washington, D.C. 20005

Gentlemen:
Please send me 50 free copies of
Medicines and your family's health.

Name_____

Street_____

City_____ State_____ Zip_____



DORSEY "FLU-GRAM"

DON'T BE LULLED BY RELATIVE LACK OF FLU LAST WINTER. THIS WINTER BE PREPARED: WHEN THE COMPLAINTS ARE COUGH AND CONGESTION, YOU CAN RELIEVE THESE SYMPTOMS WITH TUSSAGESIC TABLETS. ONE TIMED-RELEASE TABLET AT MORNING, MIDAFTERNOON AND BEDTIME BRINGS UP TO 24 HOURS' RELIEF FROM TROUBLESOME COUGH AND STUFFED AND RUNNY NOSE. TUSSAGESIC IS THE FAMOUS TRIAMINIC FORMULA, PLUS THREE OTHER PROVED CONSTITUENTS. MAKES PATIENTS MORE COMFORTABLE. FAST. ASK YOUR DORSEY REPRESENTATIVE FOR SUPPLY OF STARTER SAMPLES, OR IF FLU IS ALREADY EPIDEMIC, PHONE COLLECT. SEE BELOW.

each

Tussagesic®

timed-release tablet contains:

Triaminic® (phenylpropanolamine hydrochloride 25 mg., pheniramine maleate 12.5 mg., pyrilamine maleate 12.5 mg.)	50 mg.
Dextromethorphan hydrobromide	30 mg.
Terpin hydrate	180 mg.
Acetaminophen	325 mg.

Dosage: Adults—1 tablet, swallowed whole to preserve timed-release feature, in morning, midafternoon and at bedtime. Side effects: Occasional drowsiness, blurred vision, cardiac palpitations, flushing, dizziness, nervousness or gastrointestinal upsets. Precautions: The patient should be advised not to drive a car or operate dangerous machinery if drowsiness occurs. Use with caution in patients with hypertension, heart disease, diabetes or thyrotoxicosis.

DORSEY LABORATORIES
a division of The Wander Company
Lincoln, Nebraska 68501

clip and file under "flu"

For relief of "flu-like" symptoms
Tussagesic timed-release tablets

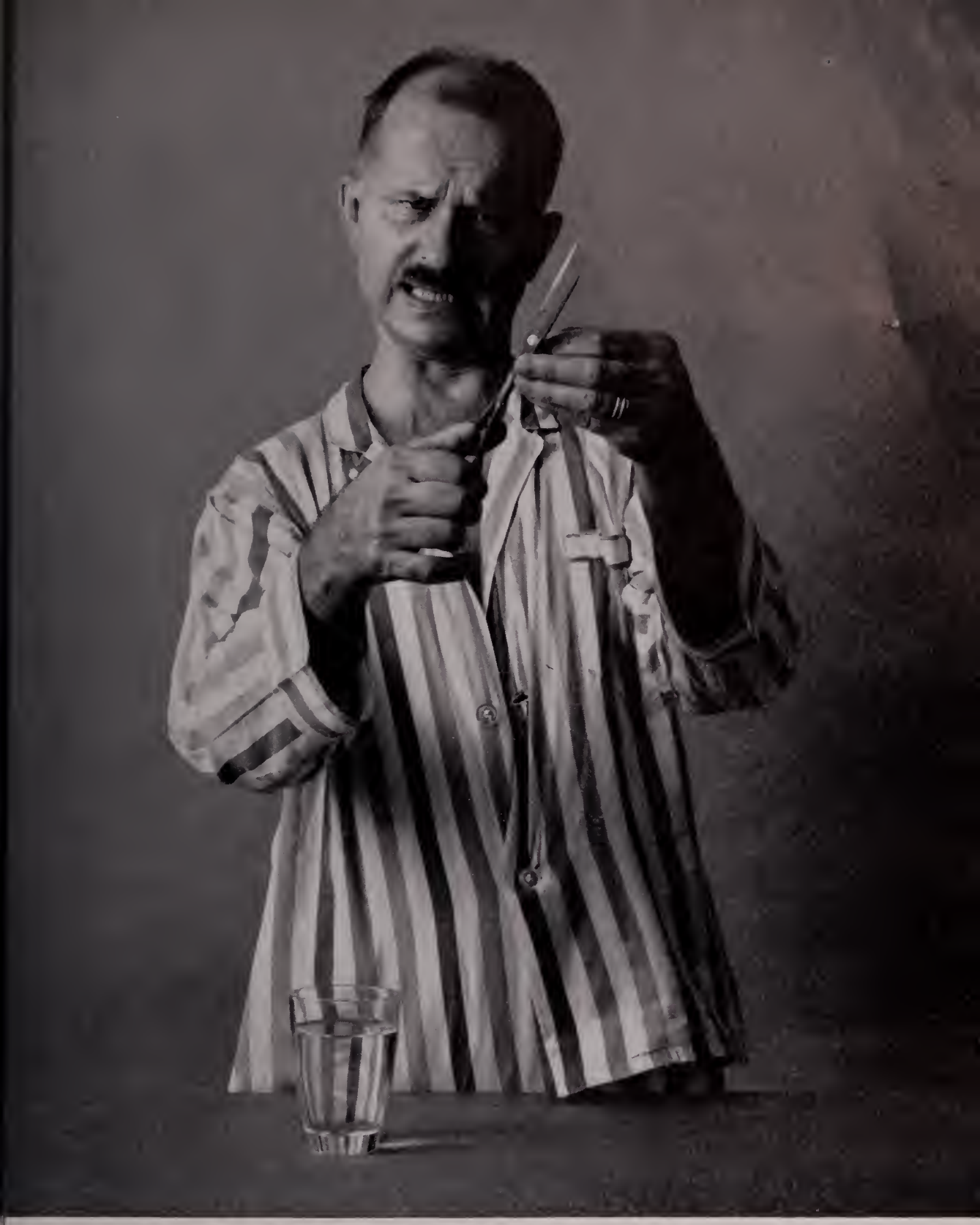
PHONE COLLECT

For emergency starter samples
to Keith Sehnert, M.D.
Medical Director
(402) 434-6311

Fast delivery by your Dorsey Representative



Maybe you don't want
your patients to halve Hygroton®chlorthalidone.



Maybe your patients complain:
Why don't they make a tablet I don't have to halve?"

Please see brief prescribing summary at the end of advertisement.



Maybe you abandoned Hygroton chlorthalidone
because there wasn't a convenient half strength.

ations: Hypertension and many types of
a involving retention of salt and water.

raIndications: Hypersensitivity and most
of severe renal or hepatic disease.

ing: With the administration of enteric-
d potassium supplements, which should
ed only when adequate dietary supple-
ation is not practical, the possibility of
bowel lesions (obstruction, hemor-
, and perforation) should be kept in
Surgery for these lesions has fre-
ly been required and deaths have oc-
d. Discontinue enteric-coated potas-
supplements immediately if abdominal
distention, nausea, vomiting, or gastro-
inal bleeding occur.

vith caution in pregnant patients, since
rug may cross the placental barrier and
se reactions which may occur in the
(thrombocytopenia, hyperbilirubinemia,
d carbohydrate metabolism, etc.) are
tial problems in the newborn.

utions: Antihypertensive therapy with
ton should always be initiated cau-
y in postsympathectomy patients and
ients receiving ganglionic blocking
s or other potent antihypertensive drugs,
rare. Reduce dosage of concomitant
ypertensive agents by at least one-half.
turates, narcotics or alcohol may po-
te hypotension. Because of the possi-
of progression of renal damage, peri-
determination of the BUN is indicated.
ntinue if the BUN rises or liver dysfunc-
s aggravated. Hepatic coma may be
pitated.

rolyte imbalance, sodium and/or potas-
depletion may occur. If potassium deple-
should occur during therapy, Hygroton
d be discontinued and potassium sup-
ents given, provided the patient does
ave marked oliguria.

special care in cirrhosis or severe
mic heart disease and in patients re-
ng corticosteroids, ACTH, or digitalis.
estriction is not recommended.

rse Reactions: Nausea, gastric irritation,
ting, anorexia, constipation and cramp-
dizziness, weakness, restlessness, hy-
lycemia, hyperuricemia, headache, mus-
ramps, orthostatic hypotension, aplastic
ia, leukopenia, thrombocytopenia,
nulocytosis, impotence, dysuria, transient
ia, skin rashes, urticaria, purpura, nec-
ing angiitis, acute gout, and pancreatitis
epigastric pain or unexplained G.I.
toms develop after prolonged adminis-
n. Other reactions reported with this
of compounds include: jaundice, xan-
sia, paresthesia, and photosensitization.

age Dosage: One tablet with breakfast
or every other day.

ability: White, single-scored tablets of
g. and aqua tablets of 50 mg., in bot-
f 100 and 1000. (B)46-230-D

ull details, please see the complete
cribing information.

y Pharmaceuticals
ion of
y Chemical Corporation
ley, New York

Here's the Hygroton they don't have to halve



New Hygroton 50 mg. from Geigy

to go with the Hygroton 100 mg. you know



HY-5406

When the agitated geriatric disrupts the home...

His teen-age granddaughter won't invite friends home because of his outbursts.



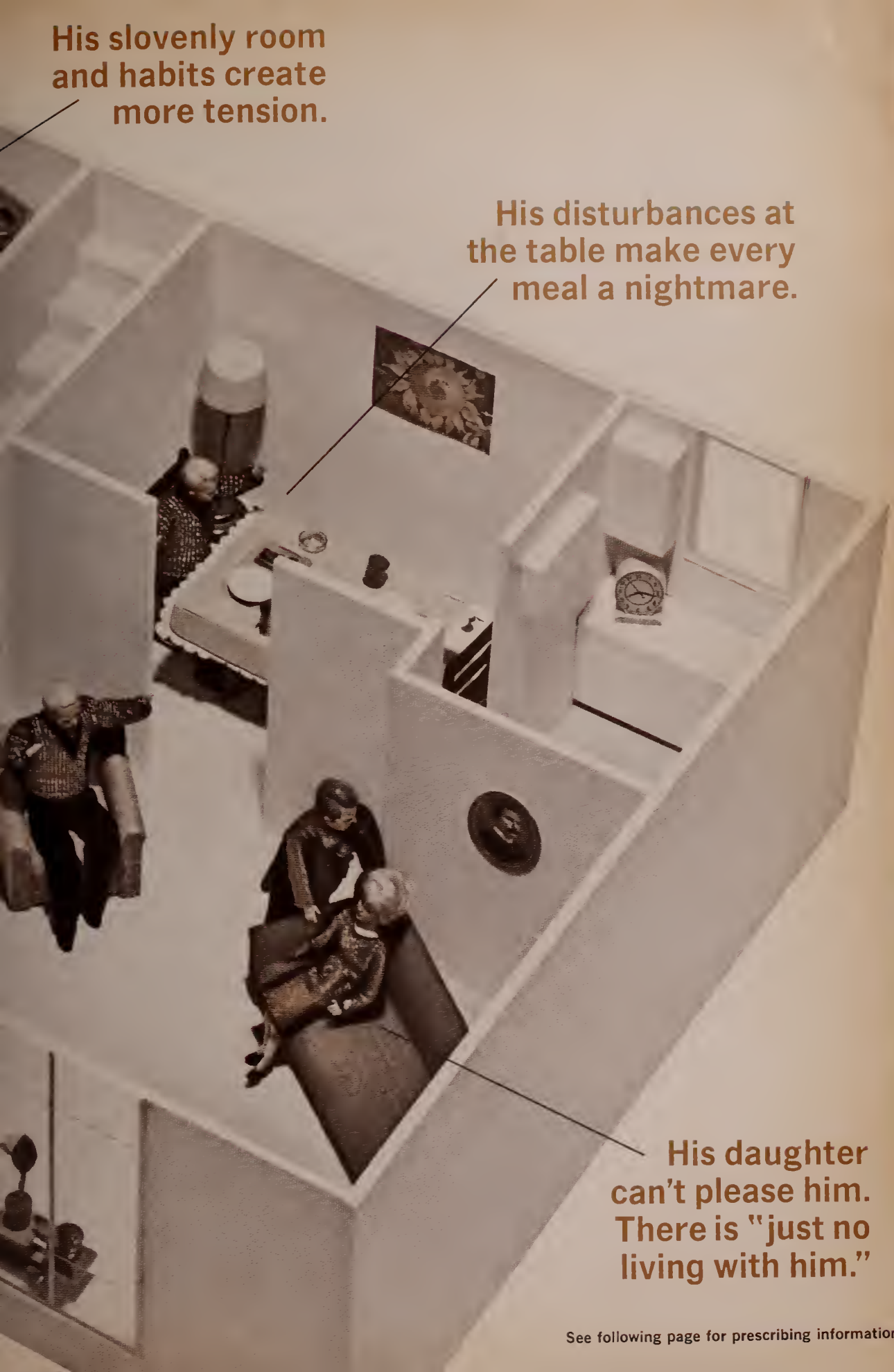
for moderate to severe anxiety

Mellaril®
(thioridazine)
25 mg. t.i.d.

SANDOZ

His slovenly room and habits create more tension.

His disturbances at the table make every meal a nightmare.



His daughter can't please him. There is "just no living with him."

See following page for prescribing information.

When the agitated geriatric disrupts the home...

Anxiety that *seriously interferes* with the individual's performance at work, at home, or in the community may be regarded as *moderate to severe* in degree.

Mellaril often recommends itself to the treatment of moderate to severe anxiety because it

- helps control the most frequent symptoms: marked tension, agitation, apprehension, restlessness, hypermotility
- often alleviates anxiety-induced somatic complaints
- frequently helps strengthen emotional resources
- helps the patient maintain realistic contact with environment, closer harmony with family

Thus, when you consider the anxiety moderate to severe... consider Mellaril.

Contraindications: Severely depressed or comatose states from any cause, and in association with or following MAO inhibitors; severe hypertensive or hypotensive heart disease.

Precautions: Hypersensitivity reactions (e.g., leukopenia, agranulocytosis) and convulsive seizures are infrequent. Pigmentary retinopathy has been observed where doses in excess of those recommended were used for long periods of time. May potentiate central nervous system depressants, atropine, and phosphorus insecticides. Where complete mental alertness is required, administer the drug cautiously and increase dosage gradually. In addition, orthostatic hypotension (especially in female patients) has been observed. Epinephrine should be avoided in treatment of drug-induced hypotension.

Side Effects: Pseudoparkinsonism and other extrapyramidal disorders are infrequent; drowsiness, especially in high doses early in treatment, may occur; nocturnal confusion, dryness of the mouth, nasal stuffiness, headache, peripheral edema, lactation, galactorrhea, and inhibition of ejaculation are noted on occasion; photosensitivity and other allergic skin reactions may occur but are extremely rare.

Before prescribing, see package insert for full product information.

for moderate to severe anxiety

Mellaril®
(thioridazine)
25 mg. t.i.d.

SANDOZ

mudrane®

for

- EMPHYSEMA
- ASTHMA
- CHRONIC BRONCHITIS
- BRONCHIECTASIS

The fast-disintegrating uncoated tablet gives relief in 15 minutes

Each tablet contains:

Potassium Iodide	195 mg.
Aminophylline	130 mg.
Phenobarbital, Caution: May be habit forming...	21 mg.
Ephedrine HCl	16 mg.

FEDERAL LAW PROHIBITS
DISPENSING WITHOUT PRESCRIPTION

Precautions: Usual for aminophylline-ephedrine-phenobarbital. Iodides may cause nausea, long use may cause goiter. Discontinue if symptoms of iodism develop.

Iodide contraindications: tuberculosis, pregnancy.

DOSAGE

One tablet, with full glass of water, 3 or 4 times daily.

Dispensed in bottles of 100 and 1000 tablets.

MUDRANE GG—Formula, dosage and package identical to Mudrane—*except*—100 mg. glyceryl guaiacolate replaces the potassium iodide. The value of Mudrane cannot be enjoyed by a small group in which K.I. is contraindicated. Mudrane GG is prepared for this group.

MUDRANE GG ELIXIR—Four 5 cc teaspoonfuls is equivalent to one Mudrane GG tablet. Dosage adjusted to age and weight of child. Mudrane GG Elixir is for pediatric patients and those who think they cannot swallow tablets. Dispensed in pint and half gallon bottles.

WM. P. POYTHRESS & CO., INC.
RICHMOND, VIRGINIA 23217
Manufacturers of ethical pharmaceuticals since 1856



The Medical Detective

Disputed Parentage

Many physicians, although qualified in the field, shun any involvement in cases of disputed parentage. This is understandable when one considers the potential social and legal entanglements that may arise from such cases. Great relief from doubt, or reuniting of families, or reinstatement of trust, however, can result from a properly conducted study, as the case here presented will illustrate. The investigation of a disputed paternity case can usually be obtained from a pathologist and/or medical director of the nearest full service blood bank.

Before a disputed paternity study is undertaken, it is all important to explain to the interested persons that a 100% unequivocal answer can be given only if tests prove that the child has blood factors which could not have been inherited from the parent in question. If all genotypes are compatible with the laws of inheritance, then the final conclusion can be given in terms of percentage validity or probability only.

A 35-year-old engineer was referred by a physician-friend, in order to resolve a doubt that was literally tearing the family apart. All of the background information that gave impetus to the doubt about the paternity of the 12-month-old son was not obtained. In the initial interview, however, it seemed that the question of paternity was the major problem affecting the family. The wife denied any possibility of paternity other than by the husband. The husband's doubts seemed to be based on the physical appearance of the child. Both were fully informed as to the capabilities and limitations of the studies to be initiated.

Results of the initial series of tests were as listed.

Mother

Blood Group B
*Rh Factors:
C–Positive; c–positive
D–Positive; d ----
E–Negative; e–positive

Duffy – a–positive
Kell – negative
M – Positive
N – Positive
P – Positive
*Probable Rh genotypes:
CDe/cde

Father

Blood Group A
*Rh Factors:
C–Positive; c–positive
D–Positive; d ----
E–Negative; e–positive

Duffy – a–Negative
Kell – Negative
M – Positive
N – Positive
P – Positive

CDe/cde

A continuing series prepared by members of the Florida Society of Pathologists.

Synirin®

ACETYLSALICYLIC ACID (ASPIRIN)..... 5 GR.
*PENTOBARBITAL (ACID)..... 1/8 GR.
*Warning: may be habit-forming

Synirin provides prompt barbiturate potentiation of aspirin without limiting the therapeutic usage of aspirin. Both pentobarbital and aspirin begin their action together promptly and last 4 or 5 hours. There is no accumulation.

LITERATURE AND CLINICAL SUPPLY AVAILABLE TO PHYSICIANS

SYNIRIN is another pharmaceutical achievement

WM. P. POYTHRESS & CO., INC.
RICHMOND, VIRGINIA 23217
Manufacturers of ethical pharmaceuticals since 1856

Baby

Blood Group O
*Rh Factors:
C–Positive; c–positive
D–Positive; d ----
E–Negative; e–positive

Duffy – a–positive
Kell – negative
M – Positive
N – Positive
P – Positive
*Probable Rh genotype:
CDe/cde

On review of these studies, it becomes readily apparent that, of all factors tested, only the ABO group is of significance in resolving the problem at hand. At first glance, the group O infant with group B mother and group A father arouses some concern. We know from statistical studies, however, that in Caucasians approximately 80% of group A individuals are of the genotype AO and approximately 95% of group B individuals are of genotype BO. It becomes obvious, therefore, that not only is a group O infant possible from this marriage, but statistically probable. Obviously, the mother is genotype BO, or the child could not

be group O. In order to prove the genotype of the father, his parents and or other children must be tested.

When these facts were made known to the parents, it became known for the first time that the father had two children by a previous marriage, and these children were available for study. Both children were found to have blood group O, thus establishing the AO genotype of the father.

On the basis of these studies, it was believed that the father could be assured, with 80% plus validity, that he was the father of the infant. He was informed that more sophisticated testing was available, although not in the local community. He chose not to seek further testing, and accepted the conclusion derived from the tests described. Following these studies, family relationships have returned to normal.

This case illustrates a service that can be rendered to a family at the community level when troublesome circumstances exist but the problem is not sufficient in scope to warrant the time, expense and inconvenience to obtain sophisticated studies which are available in only a few centers in the country.

L. E. McHenry, M.D.
Melbourne Beach

removes the mental blur

that clouds vision

SOLFOTON®

Each tablet or capsule contains
PHENOBARBITAL.....16 mg.
(Warning: may be habit forming)
BENSULFOID® (See P D R).....65 mg.
Precaution: same as 16 mg. of phenobarbital



Constructive Therapy

A Solfoton tablet or capsule at 6 hour intervals maintains sedation at the threshold of calmness, sustaining a mental climate for purposeful living.

Literature and clinical samples sent upon request.

FEDERAL LAW PROHIBITS DISPENSING WITHOUT PRESCRIPTION

AVAILABLE

Solfoton *(yellow, uncoated tablets "P")*
100s, 500s, 5000s
Solfoton Capsules *(yellow and brown)*
100s, 500s, 1000s
Solfoton S/C *(sugar-coated beige tablets)*
100s, 500s, 4000s

WM. P. POYTHRESS & CO., INC.
RICHMOND, VIRGINIA 23217
Manufacturers of ethical pharmaceuticals since 1856

Convention Press

2111 North Liberty St.
Jacksonville, Florida
32206

QUALITY BOOK PRINTING
PUBLICATIONS BROCHURES

Whatever your first requisites may be, we always endeavor to maintain a standard of quality in keeping with our reputation for fine work — and at the same time provide the service desired. Let Convention Press help solve your printing problems by intelligently assisting on all details.

YOUR Patronage Has Made Our Growth Possible

Medical Supply Company of Jacksonville



Home Office

JACKSONVILLE
4539 Beach Blvd.
Telephone FL 9-2191

ORLANDO
1511 Sligh Blvd.
Telephone GA 5-3537

TUCKER HOSPITAL, INC.

212 West Franklin Street
Richmond, Virginia

A private hospital for diagnosis and treatment of psychiatric and neurological disorders. Hospital and out-patient services.

James Asa Shield, M.D.
George S. Fultz, Jr., M.D.
Catherine T. Ray, M.D.

Weir M. Tucker, M.D.
Edward W. Gamble, III, M.D.
Gerald W. Atkinson, M.D.

AMA '67 HOUSTON

AMA 21ST CLINICAL CONVENTION • ASTROHALL • HOUSTON, TEXAS • NOVEMBER 26-29, 1967

TO ASSURE YOUR REGISTRATION

PLEASE RETURN TO:

Circulation and Records Dept. 535 North Dearborn Street
American Medical Association Chicago, Illinois 60610

FOR ADVANCE REGISTRATION OF PHYSICIANS

(PLEASE PRINT)

Name_____
(Each Physician Must Register in His Own Name)

Street

City State Zip Code

I am a Member of the AMA thru the_____State Medical Association or in the following government service:

ADVANCE REGISTRATION INFORMATION

☐ **General Registration Only** (No Fee)
Just complete coupon and return before Nov. 13, 1967. Your Advance Registration Card will be sent to you on Nov. 16.

☐ **General Registration Plus Breakfast Roundtable Reservations**

Tuesday, Nov. 28, 7-8:30 A.M.

☐ 1. Indications and Limitations of Uses of Antibiotics

☐ 2. The Moral and Ethical Aspects of Caring for the Dying Patient

Wednesday, Nov. 29, 7-8:30 A.M.

☐ 3. Management of Cerebrovascular Insufficiency

☐ 4. Adolescence, Age of Rebellion; Related Psychiatric Aspects

The price of each Breakfast is $3.50. Please indicate choice and return.

My remittance of $_____is enclosed.

These rooms are available only through the:
AMA HOUSING BUREAU
Suite 1101
1006 Main Street
Houston, Texas 77002
Phone: (713) 224-5201



HOUSTON—HOTELS & MOTELS

Map No.	HOTELS	Singles	Doubles	Twins	Suites
1.	HOTEL AMERICA	11.50-17.75	16.85-23.50	20-23.50	50-75
2.	CONTINENTAL HOUSTON MOTOR HOTEL	9-15	12-18	14-19	40-83
3.	LAMAR HOTEL††	9.50-18.50	13-22	14.50-22	35-135
4.	RICE HOTEL††	11.50-16.50	15.50-20.50	17.50-22.50	
5.	SAVOY-FIELO HOTEL††	8-12	10-14	10-14	
6.	SHAMROCK HILTON HOTEL	(HEADQUARTERS HOTEL—NO ROOMS AVAILABLE)			
7.	SHERATON LINCOLN HOTEL	12-16.50	16-20.50	16-20.50	35-50
8.	TEXAS STATE HOTEL††	13.50	10-15.50	12-16	40-65
9.	WARWICK HOTEL	15	18	22	55-80

Map No.	MOTELS	Singles	Doubles	Twins	Suites
10.	GRANT MOTEL*	7.50	8.50	9.50-10.50	
11.	HOLIDAY INN—CENTRAL	11	14	17	
12.	HOUSTONAIRE MOTOR HOTEL	12	15	18	
13.	LAS VEGAS MOTOR HOTEL	9-13.50	12-16.50	14.50-16.50	
14.	RAMADA INN	9.50	11.50	11.50-20.50	33-37.50
15.	ROMAN INN	9-10	12-13	15-16	
16.	SHERITON OAKS INN*	10	12	14	
17.	TIDELANOS MOTOR INN	9-10	13-14	13-16	35
18.	TOWERS MOTOR HOTEL	(CO-HEADQUARTERS HOTEL—NO ROOMS AVAILABLE)			
19.	29 PALMS MOTOR HOTEL*	6.75-7.75	8.75-9.75		
20.	WHITE HOUSE MOTOR HOTEL	9-12	10-12	12-16	

*No restaurant or coffee shop on premises
††No swimming pool
All rooms 100% air-conditioned

Scientific Papers

And Exhibits

Sought For

Annual Meeting

See Page 1050

Pediatric Care Center, Inc.

of Broward County, Florida

A Non-Profit Home for Mentally Retarded, Emotionally and Physically Handicapped Children.

Licensed by the Florida State Board of Health

Licensed M.D. On Call 24 Hours a Day

Clinical Psychologist Available

For information write or call:

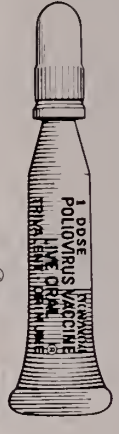
Ann Storck, R.N., F.A.A.M.D.
Executive Director
901 N.W. Ninth Avenue
Fort Lauderdale, Florida 33311
Telephone (305) 522-6934

New DISPETTE™
Single dose disposable units

- No measuring—no droppers—no bottles
- Full dosage without waste or spillage
- Space-saving refrigerator package
- Practical and economical

Poliovirus Vaccine
Live, Oral, Trivalent

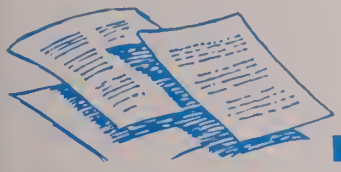
ORIMUNE®



CONTRAINDICATIONS and PRECAUTIONS: Do not inject this vaccine. Postpone vaccination in those with acute illness; in any condition having an adverse effect on the immune response mechanism (leukemias, lymphogenous diseases, dysgammaglobulinemias, during treatment with immune serum globulins or with cancer chemotherapy agents, etc.); in advanced debilitated states; or if there is persistent vomiting or diarrhea, or clinical signs of virus (including enterovirus) infection. Live measles and oral poliovirus vaccines should probably be given separately.
SIDE EFFECTS of significance have not been reported. However, the risk of vaccine-induced poliomyelitis, estimated to be from 1:2,500,000 to 1:50,000,000 should be considered.
Supplied in trays of 10. Order through your Lederle Representative or regular source of supply.

Lederle

447-7—4964



Letters

Dear Editor:

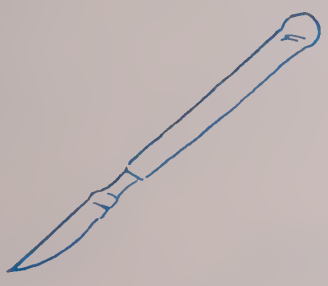
I have recently re-evaluated my thoughts concerning participation in government health programs.

I have previously declined to sign statements which include the "no discrimination" clause, since, in common with most other doctors, I made the moral decisions implicit in Title VI long before the federal statute was passed. I have objected, and I still object, to certifying my moral status to a governmental agency.

It is apparent, however, that by declining to sign the statement as written, I made it impossible for me to participate in the Hillsborough County Demonstration Project, with the aims of which I was in general accord. Since the federal government has decided that medical care for the indigent will henceforth be a function of government, and since it is unlikely that doctors in the future will not be able to provide care for the indigent in the traditional ways, but only through government programs, we must accept an unpalatable means in order to obtain a desirable end.

Accordingly, in order that I could continue caring for these patients under the Hillsborough County Demonstration Project, I then prepared to sign, without deletion of the Title VI certification, a copy of the participation agreement.

COLLIN BAKER, M.D.
TAMPA

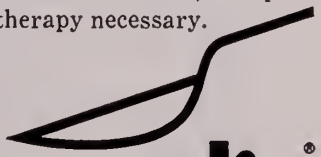




One by one the family's downed Because the G.I. bug's around

Parepectolin for quick relief of acute diarrhea
...soothes colicky pain with paregoric*
...consolidates fluid stools with pectin
...adsorbs irritants with kaolin,
and protects intestinal mucosa

Whether it's a 24-hour "bug", a food problem, or simply nervousness and anxiety, Parepectolin will bring the diarrhea under control until etiology can be determined. In some cases, Parepectolin may be all the therapy necessary.



Parepectolin®

Each fluid ounce of creamy white suspension contains:
*Paregoric (equivalent) (1.0 dram) 3.7 ml.
Contains opium (¼ grain) 15 mg. per fluid ounce.
warning: may be habit forming
Pectin (2½ grains) 162 mg.
Kaolin (specially purified) (85 grains) 5.5 Gm.
(alcohol 0.69%)
Usual Adult Dose: One or two tablespoonfuls three times daily.
Usual Children's Dose: One or two teaspoonfuls three times daily.

ROERER

WILLIAM H. RORER, INC.
Fort Washington, Pa.



The relief received from the first Trocinate 400 mg. tablet is so prompt that the discomfort of diarrhea ceases to be a bother. May be repeated every four hours.

Upon request, a supply of Trocinate 400 mg. with literature will be sent to physicians for their personal use.

WM. P. POYTHRESS & CO., INC.
RICHMOND, VIRGINIA 23217
Manufacturers of ethical pharmaceuticals since 1856



National and Regional Meetings in Florida

November

Gerontological Society, Princess Martha Hotel, St. Petersburg, Nov. 9-11.

Southern Medical Association, Miami Beach, Nov. 13-16.

National Federation of Catholic Physicians' Guild, Miami, Nov. 9-11.

Management of Trauma and Disaster Medical Problems, Carillon Hotel, Miami Beach, Nov. 10-11.

December

American Academy of Orthopaedic Surgeons, Bayfront Auditorium, Miami, Dec. 1-3.

April

American Radium Society, Fontainebleau Hotel, Miami Beach, Apr. 7-11.

American Broncho-Esophagological Association, Hollywood Beach Hotel, Hollywood, Apr. 21-22.

American Cleft Palate Association, Deauville Hotel, Miami Beach, Apr. 25-27.

American Hospital Association, Hollywood Beach Hotel, Hollywood, Apr. 25-26.

American Laryngological Association, Hollywood Beach Hotel, Hollywood, Apr. 25-26.

American Laryngological, Rhinological and Otological Society, Hollywood Beach Hotel, Hollywood, Apr. 21-26.

American Otological Society, Hollywood Beach Hotel, Hollywood, Apr. 18-20.

American Orthopaedic Association, Boca Raton Club, Boca Raton, Apr. 22-25.

American Academy of Facial Plastic and Reconstructive Surgery, Diplomat Hotel, Hollywood Beach, Apr. 27-May 1.

THE DUVALL HOME for RETARDED CHILDREN

A home offering the finest custodial care with a happy home-like environment. We specialize in the care of infants, bed-ridden children and Mongoloids.

For further information write to

MRS. A. H. DUVALL GLENWOOD, FLORIDA

b.i.d.

The sensible schedule that covers the patient day and night

our objective in the use of a broad-spectrum antibiotic rolonged action, with high blood levels, then you know b.i.d. DECLOMYCIN is considered to be a sible dosage schedule.

maintenance dosage of DECLOMYCIN be kept at this convenient schedule ause of its unusually high effective blood tissue levels.

b.i.d. dosage of DECLOMYCIN gives you comfortable assurance that the patient ell-covered, *day and night.*

linical practice, blood levels produced by erapeutic dose of DECLOMYCIN are n, prolonged, and effective; because of n serum binding and slow renal clearance. d if there's a broader susceptibility tern of organisms, we've yet to see it.

re is no need to give higher daily dosage n 300 mg b.i.d., except in venereal diseases Eaton Agent pneumonia.

DECLOMYCIN®
DEMETHYLCHLORTETRACYCLINE

lederle

scribing information on next page.

b.i.d. The sensible schedule that covers th patient day and night

DECLOMYCIN Demethylchlortetracycline should l equally or more effective therapeutically than oth tetracyclines when the offending organisms a: tetracycline-sensitive.

Contraindication: History of hypersensitivity t demethylchlortetracycline.

Warning—In renal impairment, usual doses may lea to excessive accumulation and liver toxicity. Under suc conditions, lower than usual doses are indicated, and, therapy is prolonged, serum level determinations may b advisable. A photodynamic reaction to natural or artif cial sunlight has been observed. Small amounts of dru and short exposure may produce an exaggerated sur burn reaction which may range from erythema to sever skin manifestations. In a smaller proportion, phot allergic reactions have been reported. Patients shoul avoid direct exposure to sunlight and discontinue dru at the first evidence of skin discomfort. Necessary subse quent courses of treatment with tetracyclines should b carefully observed.

Precautions—Overgrowth of nonsusceptible organism may occure. Constant observation is essential. If new in fections appear, appropriate measures should be taken In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptom have disappeared rapidly upon cessation of treatment

Side Effects—Gastrointestinal system—anorexia nausea, vomiting, diarrhea, stomatitis, glossitis, entero colitis, pruritus ani. Skin—maculopapular and erythema tous rashes. A rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and dis coloration of the nails (rare). Kidney—rise in BUN apparently dose related. Transient increase in urinary output, sometimes accompanied by thirst (rare). Hyper sensitivity reactions—urticaria, angioneurotic edema anaphylaxis. Teeth— dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs discontinue medication and institute appropriate therapy.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

In the treatment of syphilis a dosage schedule of a total of 12 to 18 Gm. given in equally divided doses over a period of 10 to 15 days should be followed. Close follow-up observation of the patient is recommended, including appropriate laboratory tests, since demethylchlortetracycline has not had adequate evaluation in all stages of syphilis. Spinal fluid examination should be included as part of this follow-up.

Acute gonococcal anterior urethritis in males has been treated effectively with a single dose of 600-900 mg. of DECLOMYCIN Demethylchlortetracycline. Individuals unable to tolerate large single doses due to gastrointestinal side effects may be treated with 150 mg. every 6 hours for a minimum of 4 doses or 300 mg. every 12 hours for a minimum of 2 doses. Females should be treated with a dosage of 150 mg. every 6 hours or 300 mg. every 12 hours until a cure is effected.

Primary Atypical Pneumonia (Eaton Agent): The average adult daily dosage is 900 mg. in 3 divided doses for six days.

LEDERLE LABORATORIES, A Division of American Cyanamid Company, Pearl River, N.Y.

Lederle

485-7—5993



Ballast Point Manor

5226 Nichols St., P. O. Box 13467 Phone 831-4191
Tampa, Florida

Don Savage, Owner-Manager

Care of mild mental cases, senile disorders and invalids. Alcoholics treated. Aged adjudged cases will be accepted on either permanent or temporary basis.

Anderson Surgical Supply Co.

Established 1916

Distributors of Known Brands of Proven Quality

TELEPHONE 229-8504
Morgan at Platt, P. O. Box 1228
TAMPA, FLORIDA 33601

TELEPHONE 376-8253
236 S.W. 4th Ave.
GAINESVILLE, FLORIDA

TELEPHONE 896-3107
556 9th St., South
ST. PETERSBURG, FLORIDA

TELEPHONE CHerry 1-9589
1818 N. Orange Ave.
ORLANDO, FLORIDA

Highland Hospital

Asheville, North Carolina

Founded 1904

A DIVISION OF THE DEPARTMENT OF PSYCHIATRY
OF DUKE UNIVERSITY

Accredited by the Joint Commission on Accreditation and Certified for Medicare

Complete facilities for evaluation of and intensive treatment of psychiatric patients, including individual psychotherapy, group therapy, psychodrama, electro-convulsive therapy, Indoklon convulsive therapy, drugs, social service work with families, family therapy, and an extensive and well organized activities program, including occupational therapy, art therapy, athletic activities and games, recreational activities and outings. The treatment program of each patient is carefully supervised in order that the therapeutic needs of each patient may be realized.

Complete modern facilities with 85 acres of landscaped and wooded grounds in the City of Asheville.

Brochures and information on financial arrangements available
Contact: Mrs. Elizabeth Harkins, ACSW, Coordinator of Admissions

or

Charles W. Neville, Jr., M.D.
Assistant Professor of Psychiatry and Medical Director
Area Code 704 - 253-2761

Thomas B. Slade — Fifty Years in Florida — J. Beatty Williams

Surgical SUPPLY COMPANY

HAMILTON — RITTER — SKLAR — BURDICK
CLAY-ADAMS — B-D — BARD-PARKER — TYCOS
BAUM — WELCH-ALLYN AND MANY, MANY OTHERS

Ph. 355-8391 — P. O. Box 2580 — 1050 W. Adams Street — Jacksonville, Fla. 32203



P. L. DODGE MEMORIAL HOSPITAL

M. G. Isaacson, M.D.
Medical Director
1861 N.W. South River Drive
Miami, Florida
Phone 379-1448

A nonprofit-voluntary hospital for the treatment of nervous and mental disorders and the problems of drug addiction and alcoholic habituation. Modern diagnostic and treatment procedures including—Psychotherapy, Insulin, & Electroshock, when indicated. Adequate facilities for recreation and out-door activities. Admissions are made without regard to race, color or national origin.

Information on request
Member NAPPH, American Psychiatric Assn., & American Hospital Assn.

APPALACHIAN HALL

ASHEVILLE — Established 1916 — NORTH CAROLINA



An Institution for the diagnosis and treatment of Psychiatric and Neurological illnesses, rest, convalescence, drug and alcohol habituation.

Insulin Coma, Electroshock and Psychotherapy are employed. The Institution is equipped with complete laboratory facilities including electroencephalography and X-ray.

Appalachian Hall is located in Asheville, North Carolina, a resort town, which justly claims an all around climate for health and comfort. There are ample facilities for classification of patients, rooms single or en suite.

Wm. Ray Griffin Jr., M.D.
Robert A. Griffin, M.D

Mark A. Griffin Sr., M.D.
Mark A. Griffin Jr., M.D.

Night Leg Cramps . . . Unwelcome Bedfellow

In Diabetes[1], Arthritis[2], and Peripheral Vascular Disorders[2]



now . . . specific therapy for night leg cramps

Walker

QUINAMM™

Consistently effective, QUINAMM provided complete relief in 94% of 200 patients studied, many of whom were severe cases refractory to other medication.[3] Your prescription for one tablet at bedtime often controls painful night cramps with the initial dose . . . helps restore restful sleep.

THE NATIONAL DRUG COMPANY
DIVISION OF RICHARDSON MERRELL INC
PHILADELPHIA, PENNSYLVANIA 19144

Prescribing Information: Composition: Each white, beveled, compressed tablet contains: Quinine Sulfate 260 mg. and Aminophylline 195 mg. **Contraindication:** QUINAMM is contraindicated in pregnancy because of its quinine content. **Precautions:** Aminophylline may produce intestinal cramps in some instances, and quinine may produce symptoms of cinchonism, such as tinnitus, dizziness, and gastrointestinal disturbance. Discontinue use if ringing in the ears, deafness, skin rash, or visual disturbances occur. **Dosage:** One tablet upon retiring. Where necessary, dosage may be increased to one tablet following the evening meal and one tablet upon retiring. **Supplied:** Bottles of 100 and 500 tablets.

References: 1. Shumon, C.: Am. J. Med. Sci., 225:54, 1953. 2. Perchuk, E., et al.: Angiology, 12:102, 1961. 3. Rowls, W., et al.: Med. Times, 87:818, 1959.

6/67 Q-706A


at the site of infection
(where it counts)...

Ilosone® provides more antibacterial activity than any other oral erythromycin

Acid stable, better absorbed... Ilosone produces faster, higher, more prolonged blood levels, even in the presence of food[1-3]

Because it is the most active form of oral erythromycin, Ilosone can help assure consistently greater antibacterial activity at the site of infection. Ilosone produces peak antibacterial blood levels two to four times those of other erythromycin preparations.[1,2] Not only are these levels attained earlier, but they are maintained for much longer periods. Even the presence of food does not seem to affect the activity of Ilosone.[1,3]

In the treatment of patients with bacterial infections susceptible to erythromycin, Ilosone has compiled an excellent therapeutic record. Since it exerts its greatest activity against gram-positive organisms, it is particularly useful in common respiratory and soft-tissue bacterial infections. Ilosone kills—not merely inhibits—streptococci, pneumococci, and more strains of staphylococci than any other macrolide antibiotic. This bactericidal action, coupled with the high antibacterial levels attained, makes Ilosone especially valuable in patients with low host resistance, such as infants, debilitated individuals, and diabetics.

Ilosone has shown no cross-resistance with penicillin and may be effective against organisms that have become resistant to that agent. Despite its high antibacterial activity, Ilosone has demonstrated a low incidence of side reactions. Blood dyscrasias, ototoxicity, and tooth staining have not been observed. Infrequent cases of drug idiosyncrasy, manifested by a cholestatic jaundice, have occurred, but there have been no known definite residual effects.

Now available:
New! Ready-mixed Ilosone Liquid 125! (Contains erythromycin estolate equivalent to 125 mg. erythromycin base per 5-cc. teaspoonful.)

701464

Ilosone®
Erythromycin Estolate

Lilly

(See next page for prescribing information.)

Ilosone®/the most active oral form of erythromycin

Description: Ilosone is the most active form of oral erythromycin that has been developed. Because it is stable in acid, well absorbed, and excreted in lesser amounts in the bile, it provides faster, higher, and longer-lasting levels of antibacterial activity (ABA) in the serum, even when taken with food, than do comparable doses of erythromycin.

Indications: Ilosone is indicated in infections caused by micro-organisms sensitive to its action—especially staphylococci, hemolytic streptococci, and pneumococci.

It has been effective in streptococcus infections, particularly acute bacterial pharyngitis and tonsillitis; staphylococcus disease, including soft-tissue infections, furunculosis, abscesses, cellulitis, carbuncles, and wound infections; pneumococcus pneumonia and acute bronchitis with pneumococci on culture, bronchopneumonia, and otitis media.

In serious staphylococcus infections, erythromycin preparations should be used only in combination therapy with other antimicrobial agents; surgical procedures should be performed when indicated, and large doses of the antimicrobial agents should be employed.

Penicillin is the drug of choice for syphilis and gonorrhea, but Ilosone in multiple 500-mg. doses has been useful in patients with a history of penicillin allergy. Also, other infections due to susceptible bacteria in patients hypersensitive to penicillin or other antibiotics may be considered for treatment with Ilosone.

Contraindications: Known history of sensitivity to this drug; preexisting liver disease or dysfunction.

Adverse Reactions: Hepatic dysfunction with or without clinical jaundice has been reported infrequently. Changes in liver function tests indicative of intrahepatic cholestasis appear to be the result of individual idiosyncrasy. Findings subsided when treatment was discontinued. Occasionally, symptoms simulated extrahepatic obstructive jaundice or the colic of biliary tract disease.

When jaundice appeared to be related to use of the drug, laboratory findings were characterized by increased direct-reacting bilirubin, elevated alkaline phosphatase levels, negative or weakly positive cephalin flocculation and thymol turbidity tests, elevated serum glutamic oxalacetic transaminase levels, peripheral eosinophilia, and normal cholecystograms.

Gastro-intestinal disturbances not associated with hepatic effects and occasional allergic manifestations (urticaria, skin eruptions, and, rarely, anaphylaxis) have been reported. The normal intestinal gram-negative bacterial flora is not appreciably altered by erythromycin drugs.

Administration and Dosage: Ilosone is administered orally.

Infants and children under twenty-five pounds, 5 mg. per pound every six hours; twenty-five to fifty pounds, 125 mg. every six hours. Adults and children over fifty pounds, 250 mg. every six hours.

For severe infections, double the dosage. When larger doses are indicated, consider parenteral erythromycin therapy. In beta-hemolytic streptococcus infections, maintain treatment for ten days to prevent rheumatic fever or glomerulonephritis.

In syphilis, a total of 20 to 30 Gm. is administered in divided doses for ten to fifteen days. Close follow-up is necessary since erythromycin drugs have not had adequate evaluation in all stages of syphilis. Examination of spinal fluid is recommended during follow-up.

In gonorrhea, the dosage is 500 mg. four times a day for four days. Patients with a suspected lesion of syphilis should have a dark-field examination before receiving antibiotics and monthly serologic tests for three months. For detailed information, consult the package literature.

How Supplied: Pulvules® Ilosone, Capsules, N.F., 125 mg.* and 250 mg.*

Ilosone Liquid 125, Oral Suspension, U.S.P., 125 mg.* per 5-cc. teaspoonful.

Ilosone, 125, for Oral Suspension, N.F., 125 mg.* per 5-cc. teaspoonful.

Ilosone Drops, 5 mg.* per drop.

Tablets Ilosone Chewable, N.F., 125 mg.*

*Base equivalent. [080967]

References: 1. Griffith, R. S., and Black, H. R.: Am. J. M. Sc., *247*:69, 1964. 2. Griffith, R. S., and Black, H. R.: Antibiotics & Chemother., *12*:398, 1962. 3. Hirsch, H. A., Pryles, C. V., and Finland, M.: Am. J. M. Sc., *239*:198, 1960.

Additional information available to physicians upon request. Eli Lilly and Company, Indianapolis, Indiana 46206.

Lilly

701464

Meetings

Approved by FMA Committee on Postgraduate Education

November

13-17 Selected Topics in Cardiology, Mt. Sinai Hospital of Greater Miami Auditorium, Miami Beach.

16-17 Obstetrics & Gynecology Seminar, J. Hillis Miller Health Center, Gainesville.

December

2 RX for the Future — Horizons of Medicine, 1967. Gulf Life Insurance Company, Gulf Life Tower, Jacksonville.

14-16 Modern Concepts in Surgery and Management of the Lower Extremity Amputee, Americana Hotel, Miami Beach.

January

4- 7 Recent Advances in Local Anesthetics and Regional Anesthesia, Eden Roc Hotel, Miami Beach.

15-19 Neurology for the Internist, Eden Roc Hotel, Miami Beach.

18-20 Pediatric Seminar, J. Hillis Miller Health Center, Gainesville.

25-26 Obstetrics & Gynecology Seminar, J. Hillis Miller Health Center, Gainesville.

26-28 Current Results of Treatment of Gynecological Cancer, Eden Roc Hotel, Miami Beach.

28-Feb. 1—Infectious Disease in Children, Deauville Hotel, Miami Beach.

March

2 Current Medical Concepts, Watson Clinic, Lakeland.

A COMPLETE BUSINESS SERVICE

Professional Management

FOR THE MEDICAL AND DENTAL PROFESSIONS

PM FLORIDA

233 Fourth Ave, N.E.
St. Petersburg, Florida
Phone 898-5074

1855 Hillview Street
Sarasota, Florida
Sarasota Phone 958-4493
4771 Bilmark
Ft. Myers, Florida
Ft. Myers Phone 936-3162

PROFESSIONAL MANAGEMENT FOR PHYSICIANS AND DENTISTS since 1932 PM ©

417 Executive Building
1175 N.E. 125th St.
Miami, Florida 33125
Dade Phone 751-2101
Broward Phone 523-0286

Affiliates of Black & Skaggs Associates
Battle Creek, Michigan

Hill Crest
HOSPITAL
(Formerly Hill Crest Sanitarium)

7000 5TH AVENUE SOUTH
Box 2896, Woodlawn Station
Birmingham, Alabama 35212
Phone: 205 - 836-7201

A patient centered independent hospital for intensive treatment of nervous disorders . . .

Hill Crest Hospital was established in 1925 as Hill Crest Sanitarium to provide private psychiatric treatment of nervous or mental disorders. Individual patient care has been the theme during its 42 years of service.

Both male and female patients are accepted and departmentalized care is provided according to sex and the degree of illness.

In addition to the psychiatric staff, consultants are available in all medical specialities.

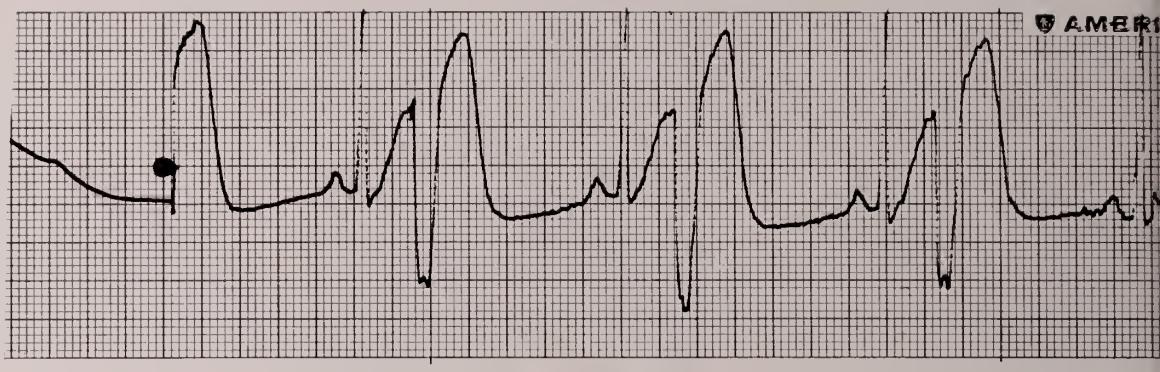


MEDICAL DIRECTOR:
James A. Becton, M.D., F.A.P.A.

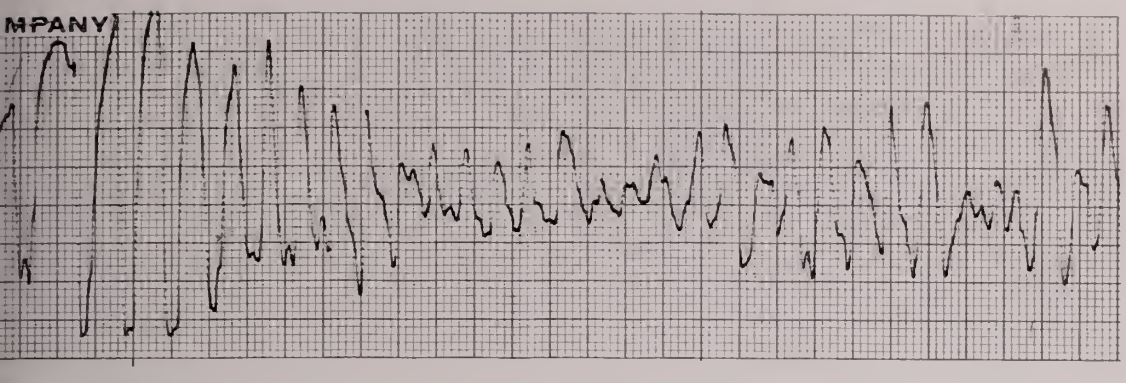
CLINICAL DIRECTORS:
James K. Ward, M.D., F.A.P.A.
Hardin M. Ritchey, M.D., F.A.P.A.

HILL CREST is a member of:
AMERICAN HOSPITAL ASSOCIATION . . . NATIONAL ASSOCIATION OF PRIVATE PSYCHIATRIC HOSPITALS . . . ALABAMA HOSPITAL ASSOCIATION . . . BIRMINGHAM REGIONAL HOSPITAL COUNCIL.
Hill Crest is fully accredited by the Joint Commission on Accreditation of Hospitals.

Hill Crest
HOSPITAL
BIRMINGHAM, ALABAMA



Let's Preven



This, Gang!

This electrocardiogram was noted on the bulletin board of the coronary care unit of South Miami Hospital, placed there by a registered nurse. It would seem to be a striking demonstration of the value of early monitoring of all patients with myocardial infarction, proven or suspected. While this 46-year-old man was successfully defibrillated, it would have been considerably easier on all concerned if it would have been possible to monitor him earlier and to have given quinidine or procainamide when the extra systoles were noted, rather than the not always successful defibrillation.

Warren Lindau, M.D.
Miami

Deaths

Arango, Roger Joseph, Miami; born in Havana, Cuba, July 27, 1906; Tulane University School of Medicine, 1931; served internships at St. Louis University Hospital, St. Louis, Mo., and Jackson Memorial Hospital, Miami, and a residency at King's County Hospital, Brooklyn, N.Y.; served in the U.S. Army Air Force Medical Corps from 1942 to 1946, attaining the rank of captain; was a past president of the Miami Hearing Center; held membership in the American Medical Association; died Aug. 2, 1967, aged 61.

Blackmon, Heyward James, Tampa; born in Kershaw, S.C., Dec. 12, 1897; Jefferson Medical College, 1922; served an internship at Philadelphia General Hospital and a residency at the Wills Eye Hospital; served in the U.S. Army Medical Corps from 1942 to 1945, attaining the rank of lieutenant colonel; held membership in the American Medical Association; died Feb. 6, 1967, aged 70.

Blake, William Campbell, Tampa; born in Dayton, Ky., Feb. 24, 1893; Johns Hopkins University School of Medicine, 1917; served an internship with the U.S. Navy Medical Corps, attaining the rank of lieutenant, and a residency at Bellevue Hospital; practiced internal medicine in Tampa from 1938 until his death; was a past president of the Hillsborough County Medical Association, was a founder and served as president of the Hillsborough County Tuberculosis Association, a past president of the Florida State Tuberculosis Association, a past president of the Florida Society of Internal Medicine, was on the board of directors of Florida Blue Cross-Blue Shield and was a governor of the American College of Physicians for nine years; held membership in the American College of Physicians, Florida Society of Internal Medicine, West Coast Academy of Medicine and the Hillsborough County Heart Association; died Aug. 2, 1967, aged 74.

Cato, Turner Elam, Miami; born in Rome, Tenn., Dec. 8, 1903; University of Tennessee College of Medicine, 1928; became health officer for Lamar County, Ala., in 1929, holding the same office for Gilmore, Hancock and Kanawha counties in West Virginia; earned the degree of Master of Public Health from Johns Hopkins University in 1937; came to Miami in 1940 as director of the Dade County Department of Public Health; during his tenure, his accomplishments included establishing new health clinics, directing the clearing of Biscayne Bay and the Miami River, enacting the first laws requiring water and toilet facilities in all county dwellings and leading efforts for better waste disposal; was past president of the Public Health Associations of both Florida and West Virginia; held membership in the American Medical Association; was a Fellow of the American Public Health Association, Diplomate of the American Board of Preventive Medicine, Fellow of the American College of Preventive Medicine and a charter member of the American Association of Public Health Physicians; died July 8, 1967, aged 63.

Fellows, William Woods, Miami; born in Salisbury, Mo., Dec. 9, 1896; New York University School of Medicine, 1924; served an internship at Kansas City General Hospital; practiced surgery in Salisbury, Mo., from 1924 to 1931, from 1931 to 1959 was with the Veterans Administration and from 1959 until the time of his death was with the American Medical Association Council on Medical Education and Hospitals field staff; served in the U.S. Army Medical Corps from 1941 to 1945; attaining the rank of colonel; held membership in the American Medical Association, American College of Surgeons and was certified by the American Board of Surgery; died June 1967, aged 71.

McSween, John Campbell, Pensacola; born in DeFuniak Springs, Mar. 25, 1892; Tulane University School of Medicine, 1917; interned at Charity Hospital, New Orleans, La.; entered the private general practice of medicine in Bonifay in 1919 where he practiced until 1921, then moving to DeFuniak Springs and establishing a practice there and finally moving to Pensacola in 1935 to practice; in 1946 he joined the Escambia County Health Department, where he practiced until his retirement; served in the U.S. Army Medical Corps in both World Wars, attaining the rank of lieutenant colonel; was a past president of the Walton-Okaloosa and Escambia Medical societies; held membership in the American Medical Association, American College of Chest Physicians,

Gulf Coast Clinical Society, American Association of Public Health Physicians, Florida Public Health Association, Florida Association of County Health Officers and the American Public Health Association; died June 23, 1967, aged 75.

Mendelblatt, David Lee, St. Petersburg; born in Braddock, Pa., Jan. 9, 1902; George Washington University Medical School, 1927; served an internship at Braddock General Hospital and a residency at City Hospital, New York, N.Y.; practiced ophthalmology in Braddock, Pa., for 19 years before moving to St. Petersburg in 1947 where he was chief of the eye, ear, nose and throat department of the Veterans Administration Hospital, Bay Pines; was the recipient of the 1965 Israel Award of Honor and was past president of the Congregation B'nai Israel; held membership in the American Medical Association, Pennsylvania Medical Society, Allegheny (Pa.) County Medical Association and was a 32nd Degree Mason, Shriner and Kiwanian; died Aug. 22, 1967, aged 65.

Roberts, Earl Hambey, Jacksonville Beach; born in St. George, Ga., Feb. 22, 1903; Tulane University School of Medicine, 1928; interned at St. Vincent's Hospital, Jacksonville and served a residency at Albany Hospital, Albany, N. Y.; came to Jacksonville Beach in 1931 where he engaged in the private general practice of medicine until his death; held membership in the American Academy of General Practice and the Florida Academy of General Practice; died May 12, 1967, aged 64.

White, Paul Leslie, St. Petersburg; born in Omaha, Neb., Aug. 12, 1907; Ohio State University College of Medicine, 1937; served an internship at Tampa General Hospital; practiced in St. Petersburg from 1938 until the time of his death; held membership in the American Medical Association; died Aug. 16, 1967, aged 60.

Wilhoit, Sterling Edward, Quincy; born in Orange, Va., Sept. 29, 1890; Medical College of Virginia, 1914; served an internship in the U.S. Marine Hospital, Boston, and a residency at the Boston Lying-In Hospital; served in the U.S. Army Medical Corps from 1917 to 1919, attaining the rank of captain; with the exception of two years in the armed forces and two years as company physician for the Graves brothers' sawmill in Hosford, he practiced medicine in Quincy from 1919 until the time of his death; in recognition of his long years of service, Quincy and Gadsden County observed a specially proclaimed "Dr. Wilhoit Day" Jan. 25, 1962; held membership in the American Medical Association and Southeastern Surgical Congress; died July 25, 1967, aged 76.

Wright, Peter Burum, Orlando; born in Augusta, Ga., Dec. 20, 1896; University of Georgia College of Medicine, 1920; interned at Fairmount Hospital, Fairmount, W. Va., and served a residency at the University Hospital, Augusta, Ga.; was appointed to the faculty of the Medical College of Georgia in 1924, appointed associate professor of orthopedic surgery in 1935 and served as full professor and chief of orthopedic surgery at University Hospital, Augusta, from 1942 until 1955 when he retired and moved to Orlando where he was associated on a part time basis with the South Orlando Orthopedic Group; served as president of both the Medical Association of Georgia and the Georgia Orthopedic Society, was chairman of the Committee on Trauma, Southeastern States, of the American College of Surgeons and served on that organization's Board of Governors; held membership in the American Medical Association, American Orthopaedic Association, American Association for Surgery and Trauma, Southeastern Surgical Congress, Florida Orthopaedic Society, was a Fellow of the American College of Surgeons and an honorary member of the North Carolina, South Carolina and Georgia orthopaedic societies; died May 14, 1967, aged 70.

Young, David Richard, Palatka; born in Greensboro, N. C., June 13, 1933; University of North Carolina School of Medicine, 1960; interned at the Duval Medical Center, Jacksonville, and served a residency while in the U.S. Navy at the Mayport Dispensary, Mayport; came to Palatka in 1963 and engaged in the private general practice of medicine; served as secretary of the Putnam County Medical Society; died July 6, 1967, aged 34.

Classified Advertisements

Advertising rates for this column are $5.00 per insertion for ads of 25 words or less. Add 20¢ for each additional word.

physicians wanted

General Practitioners

GENERAL PRACTITIONER WANTED (AAGP) for north Florida college town. Vacancy in busy two man practice in medicine, pediatrics and obstetrics. Immediate excellent income with eventual full partnership. Write C-614, P.O. Box 2411, Jacksonville, Fla. 32203.

EXCELLENT OPPORTUNITY for general practitioner in community of 15,000; central Florida; 76 bed JCAH hospital. Write or call collect R. C. Thompson, Bartow Memorial Hospital, Bartow, Fla.

WANTED: General practitioner associate, leading to partnership. Practice approximately one half industrial. Ideal central Florida community. Send detailed resume to C-716, P.O. Box 2411, Jacksonville, Fla. 32203.

GENERAL PRACTITIONER wanted to take over for physician going into residency. Beach community of 10,000; 50 bed hospital. Office and equipment available. Write C-745, P.O. Box 2411, Jacksonville, Fla. 32203.

WANTED: General practitioner to associate with established young doctor. Also office space available for rent. Contact G. L. Ehringer, M.D., 1184 Oceanshore Blvd., Ormond Beach, Fla. 32074.

WANTED: Physician, internal medicine preferred, for Rainbow Lakes Estates. Community mostly retirees, Marion County, Florida. Must have Florida license. Offer: air-conditioned office rent free and utilities furnished. House available. Three hospitals radius 30 miles. Write to Joseph D. Stearns, Rt. A-2, Box 66, Dunnellon, Fla. 32630.

WANTED: General practitioner or general surgeon to replace physician going to specialize. Good opportunity in ideal central Florida city. Excellent office and equipment. Write C-780, P.O. Box 2411, Jacksonville, Fla. 32203.

Specialists

OBSTETRICIAN-GYNECOLOGIST WANTED: To associate with two man group. Large established practice in Miami; Board eligible or certified; prefer under age 35. Write P.O. Box 384, Miami Shores, Fla. 33153.

PEDIATRICIAN: Forty doctor multi-specialty group in northwest Florida has opening for board qualified pediatrician under age 40. The group would like to add at least two additional pediatricians as soon as possible. Write to Mr. L. L. Smith Jr., P.O. Box 151, Pensacola, Fla. 32502

WANTED: General surgeon, Florida licensed, military obligations fulfilled, under 40 years of age, for a growing surgical association in Miami, Florida. Board qualified surgeons only. Full details requested in letter. Write C-785, P.O. Box 2411, Jacksonville, Fla. 32203.

INTERNIST WANTED: Associate for a three man partnership. Board qualified or certified. Located in very actively growing part of metropolitan Atlanta, Georgia area. Full partnership possible in 24 months. Write P.O. Box 506, Marietta, Ga. 30062.

PATHOLOGIST WANTED: Potential $40,000. Certified. Southern college town 25,000, community hospital 225 beds. Apply American Medical Personnel, Inc., 159 E. Chicago Ave., Chicago, Ill. 60611.

ANESTHESIOLOGIST: New facility 100 beds has opening for anesthesiologist on its medical staff. Call or write Administrator or Fred H. Albee, M.D., Chief of Staff, Ormond Beach Memorial Hospital, Box 187, Ormond Beach, Fla. 32074.

RADIOLOGIST WANTED: Board certified. Director of department of radiology. New 164 bed hospital. Must have Florida license. Reply: Marcus E. Drewa, Administrator, Methodist Hospital, Jacksonville, Fla. 32209.

Miscellaneous

WANTED: Assistant medical director for medium size Florida based life insurance company. Prefer physician under 40 with Florida license. Write C-760, P.O. Box 2411, Jacksonville, Fla. 32203.

PSYCHOSOMATIC MEDICINE: Applicants now being considered for six to twelve months. Accredited fellowships in psychosomatic medicine beginning Oct. 1967 or Jan. 1968. Salary $12,000. Other openings also available at $5,000 to $7,000. Apply to John J. Schwab, M.D. or Michael J. Kehoe, M.D., Department of Psychiatry, University of Florida, Gainesville 32601.

RESIDENTS WANTED for coverage of emergency room in 250 bed general hospital. Must be Florida licensed. Positions available July 1968. Holy Cross Hospital Inc., Fort Lauderdale, Fla. 33308.

WANTED: Industrial physician for 8000 man plant. Forty hour week; no night calls; two weeks paid vacation; good insurance program; salary $18,000; position open now; age limit 55. Ideal for postcoronary or semi-retired physician. Florida license required. Write C-788, P.O. Box 2411, Jacksonville, Fla. 32203.

PHYSICIANS FOR INDUSTRIAL PRACTICE: Internationally renowned, most progressive company, excellent growth opportunity. N.Y.C., Los Angeles, San Francisco, New England and several smaller cities. $20,000-$25,000, moving and placement fees paid. Apply American Medical Personnel, Delores Susral, Director, 159 E. Chicago Ave., Chicago 60611. (312)337-4221.

INDUSTRIAL: Established clinic needs physician with some surgical and orthopedic training. Eventual partnership anticipated. Write The Mitchell Clinic, 241 W. Ashley St., Jacksonville, Fla. 32202.

INTERNIST or GENERAL PRACTITIONER wanted to join medical group or share space in suburban Miami. Write C. F. Lester, M.D., 8988 Bird Rd., Miami, Fla. 33165.

WANTED: Internist, board certified or eligible and general practitioner for long established group on southeast coast between Miami and Fort Lauderdale. Must have Florida license and completed military obligation. Guaranteed $18,000. per year. Potential much higher. Write John F. Kerwick, Manager, The Hollywood Clinic, P.O. Box 2308, Hollywood, Fla. 33022. If urgent, call collect 923-4646.

practices available

FOR SALE: Internal medicine practice, southeast coastal city, Florida. $90,000 gross. New office building. Complete equipment. Share large suite, lab, x-ray and alternate on call with two young certified internists; but own private practice. New hospital. Retiring. Write C-766, P. O. Box 2411, Jacksonville, Fla. 32203.

AVAILABLE: Otolaryngology office. Immediate occupancy. Ideal location. Excellent opportunity. Capable gross $35,000-$50,000 first year. Owner retiring. Sell or lease. Location excellent for general practice. Write C-746, P.O. Box 2411, Jacksonville, Fla. 32203.

situations wanted

OPHTHALMOLOGIST: Board certified with Florida license seeking association with ophthalmologist in practice. Age 42. Write C-781, P.O. Box 2411, Jacksonville, Fla. 32203.

WANTED: General practitioner with two years of general surgical residency seeking association with one or two doctors in central Florida area. Emory Medical School graduate. Completed military obligation. Florida license. Age 34, Married. Write C-784, P.O. Box 2411, Jacksonville, Fla. 32203.

RADIOLOGIST: Age 33, Florida license, residency just completed, wishes hospital practice in Florida. Write C-782, P.O. Box 2411, Jacksonville, Fla. 32203.

$100,000 investment possible. Physician, not Florida licensed, desires purchase of interest in extended care facility. Supervisory and administrative activities. First class facility, congenial co-owners and security of investment essential. Write C-786, P.O. Box 2411, Jacksonville, Fla. 32203.

real estate

RENTAL PROFESSIONAL SUITES: Modern professional building. Ideal location. Ample parking. 2,250 sq. ft. or any part available. Will design to tenants specifications. 1300 North Federal Highway, Lake Worth, Fla. Phone 582-1760.

FOR SALE OR LEASE: Fully equipped medical office. Five room house. Ample parking space. Downtown Key West, Fla. Ralph Herz, M.D., 420 Simonton St., Key West, Fla. 33040.

FOR SALE BY OWNER: Excellent corner location for doctors' offices. Two duplexes on premises, large parking lot across street. Full price $17,750., terms. Write P.O. Box 4282, Jacksonville or telephone 384-7709 evenings.

FOR RENT: Tampa. Office for specialist in new medical center adjacent new hospital. Abundant parking, very accessible, three treatment rooms, consultation room. About 800 sq. ft. Share space with dentist. Write C-787, P.O. Box 2411, Jacksonville, Fla. 32203.

FOR RENT: New professional office, only one on Singer Island. Ready about January. S. F. Holden, Inc., 1265 Plaza Circle, Riviera Beach, Fla. 33404. Phone 842-1441.

Miscellaneous

FOR SALE: Pathologist's microscope, 4 objectives, wide field oculars, binobular. Spencer model V 2 Bu-Haw. New condition. Write C-783, P.O. Box 2411, Jacksonville, Fla. 32203.

Florida Medical Association

735 Riverside Ave., P. O. Box 2411

Jacksonville, Florida 32203

Officers

W. Dean Steward, M.D., President Orlando
Jack Q. Cleveland, M.D., President-Elect Coral Gables
Irving E. Hall Jr., M.D., Vice President Bradenton
James T. Cook, M.D., Speaker of the House Marianna
Charles K. Donegan, M.D., Vice Speaker St. Petersburg
Floyd K. Hurt, M.D., Secretary-Treasurer Jacksonville
George S. Palmer, M.D., Immediate Past President Tallahassee
W. Harold Parham, Executive Director Jacksonville

Councils

Jesse W. Castleberry, M.D., Chairman, Council on Allied Professions and Vocations Orlando
John J. Cheleden, M.D., Chairman, Judicial Council Daytona Beach
Jere W. Annis, M.D., Chairman, Council on Legislation and Public Agencies Lakeland
Jack A. MaCris, M.D., Chairman, Council on Medical Economics St. Petersburg
James M. Ingram, M.D., Chairman, Council on Medical Services Tampa
Richard C. Dever, M.D., Chairman, Council on Scientific Activities Miami
John D. Milton, M.D., Chairman, Council on Special Activities Coral Gables
Sanford A. Mullen, M.D., Chairman, Council on Specialty Medicine Jacksonville
Mason Romaine III, M.D., Chairman, Council on Voluntary Health Agencies Jacksonville

Information for Authors

Manuscripts submitted for publication in the Journal of the Florida Medical Association should be double or triple spaced on white bond, including title page, illustration legends, charts and graphs, table headings, footnotes and bibliography.

Submit *original* manuscript and two copies. Copying by electrostatic dry process (not wet process) is preferred to tissue copies. Retain one additional copy in your office for proofreading. All material is submitted with the understanding it is subject to editing.

Photographs should be submitted as 5x7 glossy prints, untrimmed and unmounted; number each photograph *lightly* on the back with pencil and indicate top. Charts, graphs and medical illustrations should be submitted as india ink drawings on white gloss paper; remember to make details large enough to allow for photographic reduction. It is a policy of the Journal that authors pay for any cuts made to illustrate their papers.

Titles should be short, specific and clear. Omit phrases such as "The Use of," "Observations on." If paper was presented at a meeting, indicate name of organization, city, month, day and year.

Only original papers not previously published are accepted for publication. Manuscripts submitted for publication are subject to review and approval by the Journal Publications Committee. Except by invitation, only papers from members of the Florida Medical Association are considered for publication.

References should be typewritten, double or triple spaced, beginning on a new sheet of paper entitled "References." Number references in the text in order of citation and prepare bibliography in the same order. Bibliographies should conform to the style of the Index Medicus. The Journal prints only bibliographies of eight references or less; bibliographies of more than eight references are referred to at the end of the paper with the statement "References are available from the author upon request."

All manuscript pages should be numbered consecutively. Within the manuscript, numbers one to nine should be spelled out except when used for units of measurement; for numbers above nine, numerals should be used. Dorland's Medical Dictionary and Webster's International Dictionary may be used as standard references. Scientific names for drugs should be used when possible. Copyright or trade names of drugs should be capitalized.

Index to Advertisers

Abbott Laboratories
Enduron 1076a
Enduronyl 1076a
Erythrocin Sulfas 1042-1044
Eutonyl 1076a
Eutron 1076a

Anderson Surgical Supply Co. 1101

Appalachian Hall 1102

Associated Management 1081

Ballast Point Manor 1101

Bristol Laboratories
Prostaphlin 1072-1073
Tetrex F. 1030

Burroughs-Wellcome Co.
Empirin 1036a

Campbell Soups 1068a

Convention Press 1096

Dorsey Laboratories
Triaminic 1032
Tussagesic 1089

Duvall Home 1100

Gebauer Chemical Co.
Ethyl Chloride 1085

Geigy Pharmaceuticals
Butazolidin 1044-1044a
Dulcolox 1036a
Hygroton 1090-1092a
Preludin 1068a

Guild of Prescription Opticians 1084a

Highland Hospital, Inc. 1101

Hill Crest Hospital 1103

Hynson, Westcott & Dunning, Inc.
Lactinex 1027

Lakeside Laboratories, Inc.
Cantil 1086
Imferon 1076
Mercuhydrin 1045
Norpramin 1034

Lederle Laboratories
Aristocort 1033
Declomycin 1100a
Orimune 1098
Stresscaps 1079

Eli Lilly & Co.
Ilosone 1102a
Tes-Tape 1046
Tuinal 1084a
V-Cillin K 1068a

Medical Supply Co. 1096

National Drug Co.
Quinamm 1102a

Parke-Davis & Co.
Dilantin Second Cover

Pediatric Care Center 1098

Pitman-Moore Co.
Novahistine LP 1040-1041

P. L. Dodge Memorial Hospital 1102

PM of Florida 1103

William P. Poythress & Co.
Mudrane 1092a
Solfoton 1095
Synirin 1094
Trocinate 1100

A. H. Robins, Inc.
Ambar 1034a
Dimetapp 1034a
Robaxin 1044a

Roche Laboratories
Librium Back Cover

Wm. H. Rorer, Inc.
Parepectolin 1099

Rystan Company
Chloresium 1075

Sandoz
Mellaril 1092a

G. D. Searle Co.
Pro Banthine 1068a

Stuart Co.
Mylanta 1084a

Surgical Supply Co. 1102

Syntex Laboratories
Norinyl 1036a
Representatives 1037
Synalar 1036a

Tucker Hospital, Inc. 1096

S. J. Tutag
Cydril 1081

Winthrop Laboratories
NegGram 1028

WHEN ANXIETY IS A SIGNIFICANT COMPONENT OF THE CLINICAL PROFILE

LIBRIUM®
(chlordiazepoxide HCl)

Also available as
LIBRITABS™ (chlordiazepoxide)
5-mg, 10-mg, 25-mg tablets



LIBRARY
NOV 13 1967
NEW YORK ACADEMY
OF MEDICINE

Before prescribing, please consult complete product information, a summary of which follows:

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver-function tests advisable during protracted therapy.

Usual Daily Dosage: Individualize for maximum beneficial effects. *Oral*—Adults: Mild and moderate anxiety and tension, 5 or 10 mg t.i.d. or q.i.d.; severe states, 20 or 25 mg t.i.d. or q.i.d. Geriatric patients: 5 mg b.i.d. to q.i.d. (See Precautions.)

Supplied: Librium® (chlordiazepoxide HCl) Capsules, 5 mg, 10 mg and 25 mg—bottles of 50. Libritabs™ (chlordiazepoxide) Tablets, 5 mg, 10 mg and 25 mg—bottles of 100. With respect to clinical activity, capsules and tablets are indistinguishable.

Roche Laboratories • Division of Hoffmann-La Roche Inc. • Nutley, N. J. 07110

Library
New York Academy of Medicine
2 East 103rd St
New York N Y J 12-67
10029

DECEMBER, 1967
Volume 54
Number 12

The JOURNAL of the Florida Medical Association

In This Issue

Pyloric Stenosis
Metabolism Errors
Renal Insufficiency
Respiratory Distress
Carcinoma of the Cervix
Lidocaine as an Antiarrhythmic

OFFICIAL PUBLICATION OF THE FLORIDA MEDICAL ASSOCIATION

Scientific Papers and Exhibits Sought for Annual Meeting
See Page 1190

Dilantin®
(diphenylhydantoin)

PARKE-DAVIS

In untold thousands of epileptic patients... Dilantin has been, and continues to be, the bedrock of therapy.

DILANTIN is useful in the treatment of grand mal epilepsy and certain other convulsive states. Its use will prevent or greatly reduce the incidence and severity of convulsive seizures in a substantial percentage of epileptic patients, without the hypnotic and narcotizing effects of many anticonvulsant drugs.
PRECAUTIONS: Periodic examination of the blood is advisable. Nystagmus in combination with diplopia and ataxia indicates dosage should be reduced. The possibility of toxic effects during pregnancy has not been explored. ADVERSE REACTIONS: Allergic phenomena such as polyarthropathy, fever, skin eruptions, and acute generalized morbilliform eruptions with or without fever. Rarely, dermatitis goes on to exfoliation with hepatitis, and further dosage is contraindicated. Gingival hypertrophy, hirsutism, and excessive motor activity are occasionally encountered. During initial treatment, side effects may include gastric distress, nausea, weight loss, nervousness, sleeplessness, feeling of unsteadiness. Macrocytosis, megaloblastic anemia, leukopenia, granulocytopenia, thrombocytopenia, pancytopenia, agranulocytosis, and aplastic anemia have been reported. Nystagmus, lymphadenopathy, lupus erythematosus, erythema multiforme (Stevens-Johnson syndrome), and a syndrome resembling infectious mononucleosis with jaundice have occurred.
DILANTIN is supplied in several forms including Kapseals® containing 0.1 Gm. and 0.03 Gm. diphenylhydantoin sodium.
Parke, Davis & Company, Detroit, Michigan 48232

The color combinations of the banded capsules are Parke-Davis trademarks. The orange-banded white capsule identifies Parke-Davis 0.1 Gm. diphenylhydantoin sodium; the pink-banded white capsule 0.03 Gm. diphenylhydantoin sodium.

PARKE-DAVIS 015R67



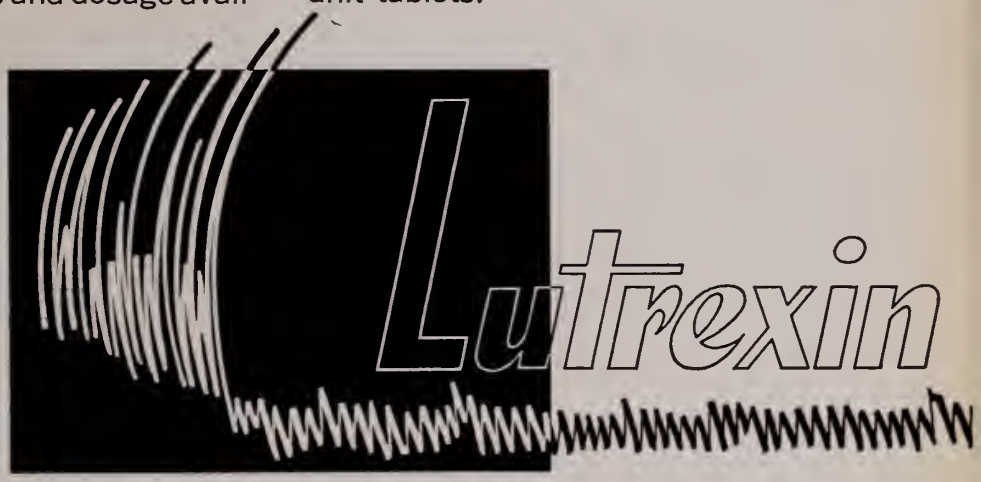
Lutrexin®

HW&D BRAND OF LUTUTRIN

3000 UNIT TABLETS

IN THE TREATMENT OF FUNCTIONAL DYSMENORRHEA AND SELECTED CASES OF PREMATURE LABOR AND 2ND AND 3RD TRIMESTER THREATENED ABORTION

- LUTREXIN, the non-steroid "uterine relaxing factor" has been found to be useful by many clinicians in controlling abnormal uterine activity.
- Literature on indications and dosage available on request.
- No side effects have been reported, even when massive doses (25 tablets per day) were administered.
- Supplied in bottles of twenty-five 3,000 unit tablets.



(In vivo measurement of Lutrexin on contracting uterine muscle of the guinea pig.)

HYNSON, WESTCOTT & DUNNING, INC. BALTIMORE, MARYLAND 21201

(LTR23)



Diagnosis:

cystitis?
pyelonephritis?
pyelitis?
urethritis?
prostatitis?

in any case,
usually gram-negative*

Therapy:

two 500 mg. Caplets® q.i.d
(initial adult dose)

NegGram

Brand of

nalidixic acid

a specific anti-gram-negative

eradicates most urinary tract infections...

- Low incidence of untoward effects; no fungal overgrowth, crystalluria, ototoxic or nephrotoxic effects have been observed.

- "Excellent" or "good" response reported *in more than 2 out of 3* patients with either chronic or acute gram-negative infections.[1]

*As many as 9 out of 10 urinary tract infections are now caused by gram-negative organisms: E. coli, Klebsiella, Aerobacter, Proteus, Paracolon or Pseudomonas[2]... However, infections of the urethra and prostate caused by non-gonococcal gram-negative organisms are believed to be less prevalent.

Summary of prescribing information

Indications: Urinary tract infections in which gram-negative bacteria are predominant, particularly *Proteus, Escherichia coli, Aerobacter, Klebsiella,* and certain strains of *Pseudomonas*. Gram-positive bacteria are less sensitive to NegGram but favorable clinical results have been observed.

Warning: Use in Pregnancy. This drug is not recommended in the first trimester of pregnancy. However, it has been used in several patients during the last two trimesters without producing apparent ill effects in either mother or fetus.

Precautions: As with all new drugs, periodic blood and liver function tests are advisable during treatment longer than 1 or 2 weeks. **This drug should be used with caution in patients with liver disease, epilepsy, severe cerebral arteriosclerosis, or severe impairment of kidney function.** Because photosensitivity reactions have been reported in a small number of cases, patients should be cautioned to avoid unnecessary exposure to direct sunlight while receiving NegGram, and if a photosensitivity reaction occurs, therapy should be discontinued. The dosage recommended for adults and children should not arbitrarily be doubled unless under the careful supervision of a physician. Should bacterial resistance develop or additional nonsensitive strains emerge, other effective antibacterial agents should be added to or substituted for NegGram.

When testing the urine for glucose in patients receiving NegGram, Clinistix® Reagent Strips or Tes-Tape® should be used since other reagents may give a false-positive reaction.

Adverse reactions: Mainly mild nausea, vomiting, and other gastrointestinal disturbances; less frequently, sleepiness, drowsiness, weakness, headache, dizziness and vertigo, and rarely cholestasis, paresthesia, thrombocytopenia, leukopenia, or hemolytic anemia in patients with a deficiency in activity of glucose-6-phosphate dehydrogenase. Itching, pruritus, rash, urticaria, mild eosinophilia, reversible photosensitivity reactions primarily involving exposed surfaces, and reversible subjective visual disturbances (overbrightness of lights, change in visual color perception, difficulty in focusing, decrease in visual acuity and double vision), occurred occasionally. Reversible increased intracranial pressure with bulging anterior fontanel, papilledema, and headache has been observed occasionally in infants and children. Toxic psychosis and brief convulsions (the latter generally in patients with possible predisposing factors, and both usually associated with excessive dosage) have been recorded in rare instances.

Dosage and administration: ***Adults*—Four Gm. daily by mouth (2 Caplets® of 500 mg. four times daily) for one to two weeks. Thereafter, if prolonged treatment is indicated, the dosage may be reduced to two Gm. daily (1 Caplet of 500 mg. four times daily). *Children*—According to age and weight: approximately 25 mg. per pound of body weight per day, administered in divided doses.**

Note: The dosage recommended above for adults and children should not arbitrarily be doubled unless under the careful supervision of a physician. Until further experience is gained, infants under 1 month should not be treated with the drug.

How supplied:

- **For adults**—Buff-colored, scored Caplets of **500 mg.**, conveniently available in bottles of 56 (sufficient for one full week of therapy) and in bottles of 1000.
- **For children**—Caplets of **250 mg.**, available in bottles of 56 and 1000.

Before prescribing, please refer to complete prescribing information.

References: (1) Based on 23 clinical papers, 1512 cases. Bibliography on request. (2) Bush, I. M., Orkin, L. A., and Winter, J. W., in Sylvester, J. C.: Antimicrobial Agents and Chemotherapy—1964, Ann Arbor, American Society for Microbiology, 1965, p. 722.

Winthrop

Winthrop Laboratories, New York, N. Y. 10016

The JOURNAL
of the Florida Medical Association

Volume 54, Number 12, December 1967

THAD MOSELEY, M.D.
Editor

Assistant Editors

JOHN M. PACKARD, M.D.
OSCAR W. FREEMAN, M.D.

Assistant Editor from the Board of Governors
JACK Q. CLEVELAND, M.D.

W. HAROLD PARHAM
Managing Editor

EUGENE L. NIXON
Associate Managing Editor

LOUISE RADER
Assistant Managing Editor

EDITH B. HILL
Editorial Consultant

ublished monthly at Jacksonville, lorida. Price $7.00 a year, single number, 70 cents. Address Journal of lorida Medical Association, P.O. Box 411, 735 Riverside Ave., Jacksonville, la. 32203. Telephone (904) 356-1571. Accepted for mailing at special rate of ostage provided for in Section 1103, ct of Congress of October 3, 1917; uthorized October 16, 1918. Entered s second class matter under Act of ongress of March 3, 1879, at the post ffice at Jacksonville, Florida, October 3, 1924. Available on microfilm beginning with the 1967 volume. Address nquiries to University Microfilms, 300 Jorth Zeeb Road, Ann Arbor, Michian 48106.

THIS ISSUE

Scientific Section

Carcinoma of the Cervix in Pregnancy, Vincent G. Stenger, M.D., Robert Mullee, M.D. and Harry Prystowsky, M.D. ... 1127
Surgical Diseases Producing Respiratory Distress in the Newborn, Richard H. Blank, M.D., Leffie M. Carlton, M.D. and Richard G. Connar, M.D. ... 1130
Lidocaine As An Antiarrhythmic Agent, Robert B. Van Cleve, M.D. ... 1137
Management of Infantile Pyloric Stenosis, Michel Gilbert, M.D. and Felipe Mencia, M.D. ... 1139
Experience in Treatment of "Non Ideal" Patients With Chronic Renal Insufficiency, Felix Lo Cicero, M. D., Lawrence Kahana, M.D. and Robert Price, M.D. ... 1144
Classification of Inborn Errors of Metabolism Associated With Mental Retardation, Charles H. Carter, M.D., Donald Carpenter, M.D. and William L. Nyhan, M.D. ... 1147

Editorials

Let There Be Light, Rev. Dr. Sidney M. Lefkowitz ... 1159
Tomorrow's Hospitals—Today, Frank G. Slaughter, M.D. ... 1159
Respiratory Distress in the Newborn, James M. Weaver, M.D. ... 1161
Infantile Pyloric Stenosis, H. Warner Webb, M.D. ... 1163

Departments

President's Page ... 1121
Others Are Saying ... 1167
The Medical Detective ... 1170
50 Years Ago in the Journal ... 1172
Government News ... 1176
News ... 1179
Public Health Topics ... 1183
Letter to Editor ... 1185
Classified ... 1188

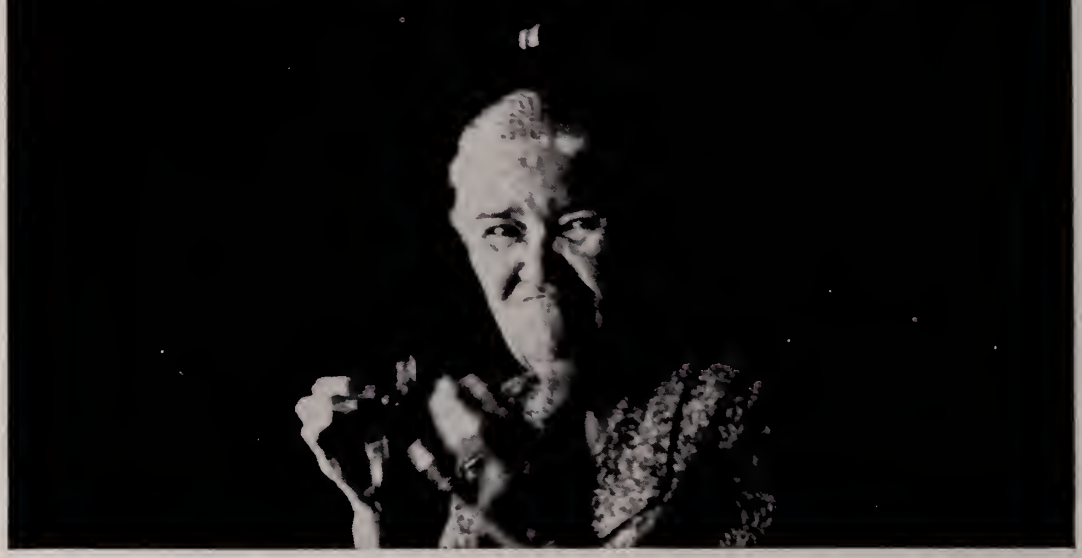
Miscellaneous

National and Regional Meetings in Florida ... 1187
FMA Approved Postgraduate Meetings ... 1186
Florida Organizations of Medical Interest, Meetings and Officers ... 1191
Florida Medical Association Officers, Councils and Committees ... 1192
Index to Volume 54 ... 1199
Information for Authors ... 1202
Index to Advertisers ... 1203

Owned and published by the Florida Medical Association, Inc. The Journal is not responsible for the opinions and statements of its contributors.

IRON DEFICIENCY

ANEMIA



Imferon®
(iron dextran injection)

There's as much iron . . . 250 mg. . . . in a 5 cc. ampul of Imferon (iron dextran injection) as in a pint of whole blood. When iron deficient patients are intolerant of oral iron . . . or orally administered iron proves ineffective or impractical . . . or if the patient cannot be relied upon to take oral iron as prescribed, Imferon (iron dextran injection) dependably increases hemoglobin and rapidly replenishes iron reserves. Precise dosage is easily calculated.

LAKESIDE

IN BRIEF: ACTION AND USES: A single dose of Imferon (iron dextran injection) will measurably begin to raise hemoglobin and a complete course of therapy will effectively rebuild iron reserves. The drug is indicated only for specifically-diagnosed cases of iron deficiency anemia and then only when oral administration of iron is ineffective or impractical. Such iron deficiency may include: patients in the last trimester of pregnancy; patients with gastrointestinal disease or those recovering from gastrointestinal surgery; patients with chronic bleeding with continual and extensive iron losses not rapidly replenishable with oral iron; patients intolerant of blood transfusion as a source of iron; infants with hypochromic anemia; patients who cannot be relied upon to take oral iron.

COMPOSITION: Imferon (iron dextran injection) is a well-tolerated solution of iron dextran complex providing an equivalent of 50 mg. in each cc. The solution contains 0.9% sodium chloride and has a pH of 5.2-6.0. The 10 cc. vial contains 0.5% phenol as a preservative.

ADMINISTRATION AND DOSAGE: Dosage, based upon body weight and Gm. Hb/100 cc. of blood, ranges from 0.5 cc. in infants to 5.0 cc. in adults, daily, every other day, or weekly. Initial test doses are advisable. The total iron requirement for the individual patient is readily obtainable from the dosage chart in the package insert. Deep intramuscular injection in the upper outer quadrant of the buttock, using a Z-track technique, (with displacement of the skin laterally prior to injection), insures absorption and will help avoid staining of the skin. A 2-inch needle is recommended for the adult of average size.

SIDE EFFECTS: Local and systemic side effects are few. Staining of the skin may occur. Excessive dosage, beyond the calculated need, may cause hemosiderosis. Although allergic or anaphylactoid reactions are not common, occasional severe reactions have been observed, including three fatal reactions which may have been due to Imferon (iron dextran injection). Urticaria, arthralgia, lymphadenopathy, nausea, headache and fever have occasionally been reported.

PRECAUTIONS: If sensitivity to test doses is manifested, the drug should not be given. Imferon (iron dextran injection) must be administered by deep intramuscular injection only. Inject only in the upper outer quadrant of the buttock, not in the arm or other exposed area.

CONTRAINDICATIONS: Imferon (iron dextran injection) is contraindicated in patients sensitive to iron dextran complex. Since its use is intended for the treatment of iron deficiency anemia only it is contraindicated in other anemias.

CARCINOGENICITY POTENTIAL: Using relatively massive doses, Imferon (iron dextran injection) has been shown to produce sarcoma in rats, mice and rabbits and possibly in hamsters, but not in guinea pigs. The risk of carcinogenesis, if any in man, following recommended therapy with Imferon (iron dextran injection) appears to be extremely small.

SUPPLIED: 2 cc. ampuls, boxes of 10; 5 cc. ampuls, boxes of 4, 10 cc. multiple dose vials.

LAKESIDE LABORATORIES, INC., Milwaukee, Wisconsin 53201



When relief means so much in keeping your G.U. patient comfortable **URISED®**

CONAL PHARMACEUTICALS INC

Clinically effective for G.U. Therapy[1-5]

There are not many drug combinations in use today which can claim to have served the medical profession for more than 50 years. Such a record reflects the continued confidence of physicians in URISED. This is not a dramatic "wonder drug"—but a *useful* one.

It fills a need in urologic and general practice—a need for a mild but reliable agent with a very low order of toxicity. It can be used alone to treat mild and uncomplicated urinary infections. It can be used as "interim therapy" while awaiting the results of urine culture. It can be used as an adjunct (to relieve pain and spasm) with almost any other form of antibacterial therapy.

The characteristic blue/green urine tells the patient that something is happening. The patient generally tells *you* that symptomatic relief follows the first dose.

REFERENCES: (1) Sands, R.X.: New York St. J. Med. 61:2598-2602, 1961; (2) Renner, M.J., et al.: Hosp. Topics 39:71-73, 1961; (3) Haas, Jr., J., and Kay, L. L.: Southwest Med. 42:30-32,1961; (4) Marshall, W.: Clin. Med. 7:499-502, 1960; (5) Strauss B.: Clin. Med. 4:307-310, 1957.

URISED®

Each Blue-Coated Tablet contains Active:

Atropine Sulfate	0.03 mg.	Methylene Blue . .	5.4 mg.
Hyoscyamine . .	0.03 mg.	Phenyl Salicylate	18.1 mg.
Methenamine . .	40.8 mg.	Benzoic Acid . . .	4.5 mg.

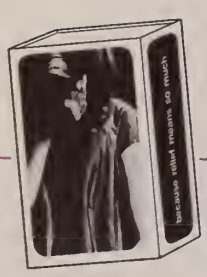
PRECAUTIONS: Administer with caution to persons with atropine idiosyncrasy or cardiac disease.

SIDE EFFECTS: Neither irritation nor untoward reactions have been reported; however, if pronounced dryness of the mouth, flushing, or difficulty in initiating micturition occur, decrease dosage. If rapid pulse, dizziness or blurring of vision occur, discontinue use immediately. Acute urinary retention may be precipitated in prostatic hypertrophy.

CONTRAINDICATIONS: Glaucoma, urinary bladder neck or pyloric obstruction, duodenal obstruction and cardiospasm. Hypersensitivity to any of the ingredients.

DOSAGE: Adults—Two tablets, orally, four times per day followed by liberal fluid intake. Acute cases—initially two tablets every hour for three doses followed by the recommended daily administration. Children—One-half the adult dose.

(*Stocked Nationally Through All Service Wholesale Druggists*)



CONAL
PHARMACEUTICALS, INC
CHICAGO, ILLINOIS 60640

MANUFACTURERS OF URICEUTICAL® SPECIALTIES

• CYSTOSPAZ® • URISEDAMINE® • ŪTRASUL® Tablets and Suspension

PRINTED IN U.S.A.

FEB 1967



PRICED SO LOW YOU CAN'T SAY NO

Steal an hour, a day, a week—fishing, cruising, lazing. Plenty of room for family and friends. Enclosed cabin, 2 full-length bunks, marine head. Famous Stamas Level Ride in any water, at all speeds. All fiberglass. V-24 Clearwater is trailerable without special permits.

WRITE Dept. F for color brochures and nearest dealer. Stamas Boats are built in Florida; enjoyed all over the world.

Stamas BOATS, INC.
Tarpon Springs, Florida 33589





DUAL PROBLEM IN PEPTIC ULCER

Relief of hyperacidity is still a primary goal in the treatment of peptic ulcer. And antacids are the most widely used means of achieving this relief. But antacids alone cannot influence the distention and bloating which so often add to ulcer distress.

THIS IS WHY MYLANTA® PROVIDES:

the two most widely used antacids—magnesium and aluminum hydroxides—to help secure rapid acid neutralization with little chance of laxation or constipation;

PLUS

the defoaming action of simethicone—to help relieve the painful gas symptoms which often accompany peptic ulcer.

Mylanta®

antacid therapy plus an added benefit

nonfatiguing flavor/smooth pleasant texture; both assure patient cooperation during long-term therapy.

Stuart Division of / ATLAS CHEMICAL INDUSTRIES, INC. / Pasadena, Calif.



President's Page

The Spirit of Giving

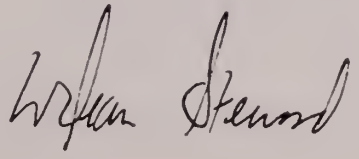
December ushers in winter . . . and Christmas. It is at this season that love of, and concern for, one's fellow man appear a bit closer to the surface, and the Western World, at least, seems to be a bit better and brighter place in which to live. The Christmas season is also a time when giving and thoughts of gifts are uppermost in the mind. The month thus seems appropriate to discuss the Florida Medical Foundation, its history and purpose.

The House of Delegates of the FMA in May 1956 authorized the establishment of a nonprofit organization "to promote better medical care in Florida." The charter was approved the same year and by-laws were adopted in January 1957. Dr. Edward Jelks, a Past President of the FMA (1937) was the first president. Subsequent amendments were made to the by-laws, and the Foundation has enjoyed a tax-exempt gift status since 1959. The revised objectives of the Foundation are (1) Improvement of the health and the medical care of the people of Florida; (2) Sponsorship of graduate and postgraduate medical education without preference for any person; (3) Aid to persons of Florida needing financial charitable assistance who are pursuing an education in medicine; (4) Aid of deserving indigent or destitute physicians who, by reason of illness or mental or physical incapacity, need charitable assistance, and (5) Promotion and sponsorship of medical research exclusively for public purposes and benefits.

The Florida National Bank of Jacksonville is the trustee for funds which have been set up by the Foundation. These include various trust funds for county societies and other medically related groups; a Loan Guarantee Plan for medical students, interns and residents, and the Past President's Memorial Fund for physicians in need.

Agreements also are in effect with the Florida State Board of Health for research and development programs and with the Florida United Community Funds, Inc. for a medical research program. The Board of Governors of the FMA constitutes the Foundation's Board of Directors, and the officers are elected from the group. Eugene Peek Jr., M.D. is the current president of the Foundation and Mr. W. Harold Parham serves as its executive secretary. Dr. Edward Jelks continues to serve as medical advisor.

This philanthropic organization is one that the physicians of Florida can be proud of, and it deserves their wholehearted support. Donations can be made directly to the Foundation or can be so designated through your United Fund gift.





"When I couldn't even smell corned beef and cabbage,
I decided it was time for you, Doc."



Maybe he doesn't know when he's well off. But you might want to prescribe long-acting Novahistine LP anyway.

Two tablets in the morning and two in the evening will usually provide day and night relief by helping to clear congested air passages for normal, free breathing. Novahistine LP is formulated to provide continuous therapeutic effect for 8 to 12 hours. The decongestant ingredients help restore normal mucus secretion and ciliary activity—physiologic defenses against infection of the respiratory tract. Use cautiously in individuals with severe hypertension, diabetes mellitus, hyperthyroidism or urinary retention. Caution ambulatory patients that drowsiness may result. Each Novahistine LP tablet contains phenylephrine hydrochloride, 25 mg., and chlorpheniramine maleate, 4 mg.

NOVAHISTINE® LP

Dow **PITMAN-MOORE** Division of The Dow Chemical Company, Indianapolis



Indications: Hypertension and many types of edema involving retention of salt and water.
Contraindications: Hypersensitivity and most cases of severe renal or hepatic disease.
Warning: With the administration of enteric-coated potassium supplements, which should be used only when adequate dietary supplementation is not practical, the possibility of small bowel lesions (obstruction, hemorrhage, and perforation) should be kept in mind. Surgery for these lesions has frequently been required and deaths have occurred. Discontinue enteric-coated potassium supplements immediately if abdominal pain, distention, nausea, vomiting, or gastrointestinal bleeding occur.
Use with caution in pregnant patients, since the drug may cross the placental barrier and adverse reactions which may occur in the adult (thrombocytopenia, hyperbilirubinemia, altered carbohydrate metabolism, etc.) are potential problems in the newborn.
Precautions: Antihypertensive therapy with Hygroton should always be initiated cautiously in postsympathectomy patients and in patients receiving ganglionic blocking agents or other potent antihypertensive drugs, or curare. Reduce dosage of concomitant antihypertensive agents by at least one-half. Barbiturates, narcotics or alcohol may potentiate hypotension. Because of the possibility of progression of renal damage, periodic determination of the BUN is indicated. Discontinue if the BUN rises or liver dysfunction is aggravated. Hepatic coma may be precipitated.
Electrolyte imbalance, sodium and/or potassium depletion may occur. If potassium depletion should occur during therapy, Hygroton should be discontinued and potassium supplements given, provided the patient does not have marked oliguria.
Take special care in cirrhosis or

For the cardiac patient on 2 pillows a night, consider one Hygroton a day.



She was the picture of arteriosclerotic heart disease in failure.
She couldn't sleep a wink without an extra pillow.
Then her doctor prescribed digitalis and Hygroton.

First, her cardiac output improved.
Then her breathing improved—
along with her urinary output.

Nights could be a lot more pleasant for patients like this in your practice.
Try it and see.

Hygroton therapy may also mean troublesome side effects for certain patients.
A summary of essential prescribing information is shown below.

Hygroton®
chlorthalidone

new 50 mg. tablet
or 100 mg. tablet

severe ischemic heart disease and in patients receiving corticosteroids, ACTH, or digitalis. Salt restriction is not recommended.
Adverse Reactions: Nausea, gastric irritation, vomiting, anorexia, constipation and cramping, dizziness, weakness, restlessness, hyperglycemia, hyperuricemia, headache, muscle cramps, orthostatic hypotension, aplastic anemia, leukopenia, thrombocytopenia, agranulocytosis, impotence, dysuria, transient myopia, skin rashes, urticaria, purpura, necrotizing angiitis, acute gout, and pancreatitis when epigastric pain or unexplained G.I. symptoms develop after prolonged administration. Other reactions reported with this class of compounds include: jaundice, xanthopsia, paresthesia, and photosensitization.
Average Dosage: 50 or 100 mg. with breakfast daily or 100 mg. every other day.
Availability: White, single-scored tablets of 100 mg. and aqua tablets of 50 mg., in bottles of 100 and 1000.
(B)R46-230-D
For full details, please see the complete prescribing information.

Geigy Pharmaceuticals
Division of
Geigy Chemical Corporation
Ardsley, New York 10502
HY-5405S

easy does it!

tear, moisten, compare—that's all!





Scientific Section

Carcinoma of the Cervix In Pregnancy

VINCENT G. STENGER, M.D., ROBERT MULLEE, M.D. and HARRY PRYSTOWSKY, M.D.

Carcinoma of the cervix in pregnancy was diagnosed in 44 women (0.76%) in the Department of Obstetrics and Gynecology of the University of Florida College of Medicine between January 1959 and March 1967. There were 15 instances of invasive cancer (0.26%) and 29 (0.50%) of in situ cancer.

The background of the patients was studied in terms of race, age and number of pregnancies. One-half the patients were white and the other half Negro. The average age of the invasive cancer group was 30.8 years (range, 23 to 38) and of the in situ series 30.5 years (range, 21 to 45 years). The total number of pregnancies in this population was 267, the average per patient equalled 6.1, and the range 2 to 19.

Diagnosis

Figure 1 shows the method of study and treatment plan. The Papanicolaou smear, the four quadrant biopsy and Schiller stain and a "superficial" conization of the cervix are all employed as diagnostic procedures, each patient being individualized as to her diagnostic work-up. The therapy for invasive cancer is immediate whereas in situ is treated at the termination of or after gestation. With basal cell hyperactivity or a lesser abnormality, repeat Papanicolaou smears are employed.

There were symptoms (abnormal bleeding) in only six patients. In 86% there was no subjective complaint. In the 38 asymptomatic women, the cancer was detected by the Papanicolaou smear in 34 (89.5%) and in four others it was detected at the time of curettage for an incomplete abortion.

In Table 1 the relation between cytology and tissue diagnosis is shown. In the invasive cancer series there was no false negative; the incidence of tumor cells was 54% and in six instances atypical and/or suspicious cells was reported. In the in situ group, however, only 7% revealed tumor cells; there were 25 cases with atypical and/or suspicious cells; in two patients, negative cytology was reported.

From the Department of Obstetrics and Gynecology, University of Florida College of Medicine, Gainesville.

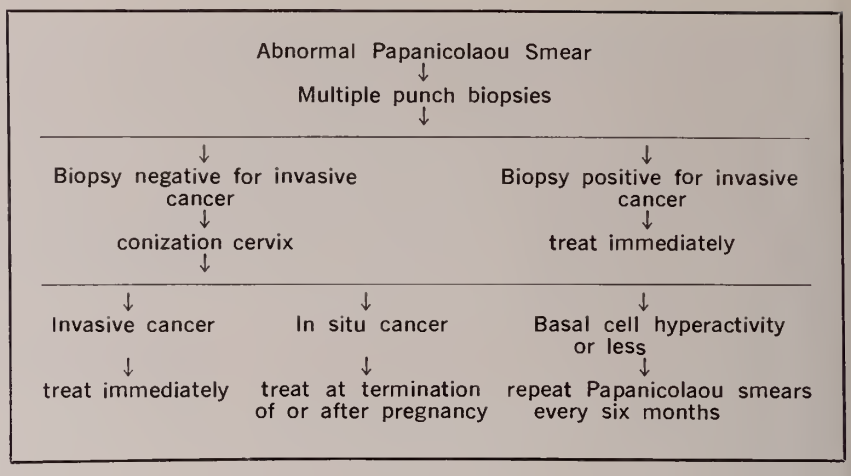


Fig. 1.—Method of Study and Treatment Plan.

There were 33 patients with repeat abnormal Papanicolaou smears and cervical biopsy not diagnostic of invasive cancer. Conizations were performed, and in six patients invasive cancer was diagnosed; in 23, in situ cancer, and in four, basal cell hyperactivity. Associated with the procedure of conization there were eight complications attributable, in large measure, to the employment initially of the "traditional" conization procedure. They were: abortion (1 instance), premature labor (2), abruptio placenta (1), intrauterine infection (1) and excess blood loss (3). With abandonment of the deep to a more superficial conization, the incidence of complications (24.2%) has been sharply reduced.

Treatment

The method of completion of pregnancy is seen in Table 2. Pregnancy in its early stages with Stage I cancer of the cervix was treated by radical Wertheim hysterectomy and pelvic lymphadenectomy; in later gestation a classical cesarean section and the above procedure were employed. In the in situ group the patients were individualized in regard to reliability for subsequent evaluation and therapy—15 were delivered per vagina, were followed in the puerperal period and were treated later in a definitive manner, whereas in 11 instances cesarean section hysterectomy was considered the best therapeutic approach. In four patients cellular abnormality was such that vaginal delivery was considered contraindicated; in these cesarean section was performed and diagnostic studies instituted in the nonpregnant state.

Thirty-two living children were obtained. There were eight abortions (therapeutic) and a

Table 1.—Relation Between Cytology and Tissue Diagnosis

Invasive Cancer		
Negative cytology	= 0	
Atypical cells	= 4	
Suspicious cells	= 2	
Tumor cells	= 7	(54%)
In Situ Cancer		
Negative cytology	= 2	
Atypical cells	= 18	
Suspicious cells	= 7	
Tumor cells	= 2	(7%)

Table 2.—Method of Completion of Pregnancy

Delivered Elsewhere	= 4
Undelivered	= 1
Delivered at University of Florida	= 39
Radical Wertheim hysterectomy and pelvic lymphadenectomy	— 2
Cesarean section and radical Wertheim hysterectomy and pelvic lymphadenectomy	— 3
Cesarean section hysterectomy	— 11
Cesarean section	— 4
Vaginal delivery	— 15
Abortion	— 3
Salpingo-oophorectomy	— 1

Table 3.—Evaluation of Laparotomy Specimen (Diagnosis established by biopsy and/or conization)

In Situ Cancer		
No tumor	= 13	
In situ cancer	= 8	(43%)
Invasive cancer	= 2	
Invasive Cancer		
No tumor	= 3	
In situ cancer	= 3	(73%)
Invasive cancer	= 5	

perinatal loss of three. The latter, all occurring during the initial phase of the program when deep conizations were performed, were related to abruptio placenta (stillborn), intrauterine infection (stillborn) and hyaline membrane disease (neonatal death).

In this series of patients the therapy for the invasive cancer consisted of x-ray and radium (2 cases) or radical surgery (10 cases). The in situ lesions were handled by hysterectomy with a wide vaginal cuff (29 patients).

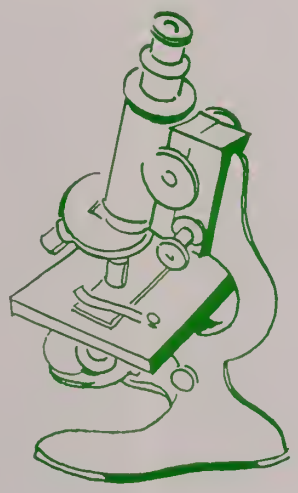
The pathologic diagnosis of laparotomy specimens (in those patients whose cancer was diagnosed by biopsy and/or conization) is shown in Table 3. In the in situ category it is seen that 10 patients still had their tumor. In the invasive group, 73% were still with tumor.

A statement in regard to success of the therapeutic regimen is of limited value. That as it may be, we are sufficiently impressed with the results thus far to postulate that there is little difference between cervical cancer in nonpregnant and pregnant women.

Summary

In conclusion, the program instituted in 1959 has proved to be a good one. It is our intention to continue a vigorous program of detection and precise diagnosis during the course of pregnancy. In regard to the latter, superficial rather than deep conization of the cervix is clearly of advantage to both mother and fetus. Also, it is to be emphasized that conization is a diagnostic tool alone; its place in therapy is clearly limited.

Dr. Stenger, 3806 S. W. Sixth Place, Gainesville 32601.



Surgical Diseases Producing Respiratory Distress in the Newborn

RICHARD H. BLANK, M.D., LEFFIE M. CARLTON JR., M.D. and
RICHARD G. CONNAR, M.D.

Respiratory failure is the leading cause of death in the newborn.[1,4] While hyaline membrane disease and neonatal atelectasis are responsible for the majority of cases, there are certain patients who have surgically correctable lesions. These infants must be identified quickly since survival may be limited to a few hours without treatment. Representative cases have been selected to illustrate some of the problems one encounters in managing these patients.

See editorial comment, page 1161

Obstruction of the Upper Airway

Disorders of the upper airway usually present with an easily audible inspiratory stridor. Many of these gradually improve with age, but certain lesions such as laryngeal webs or cysts will demand surgical attention.

Case 1.—A full term infant, with intermittent but progressive respiratory difficulty was subjected to surgical evaluation at four months of age. Marked inspiratory stridor coupled with intercostal and sternal retraction suggested an obstruction high in the airway. Direct laryngoscopy revealed a large cyst arising from the right side of the larynx. The lesion was incised and several cubic centimeters of mucoid material was evacuated resulting in complete relief of symptoms. Planned follow-up was not fulfilled and the infant was readmitted in acute respiratory distress seven months later, dying shortly thereafter in the emergency room. Figure 1 shows the lesion at autopsy which extends well down into the larynx. Elective marsupialization of the cyst would have been curative.

Masses low in the neck may obstruct the thoracic inlet to such a degree that respiratory embarrassment occurs.

Case 2.—A premature infant seemed to be well until two weeks of age when respiratory distress gradually appeared. Labored ventilatory effort and an associated fluctuant mass in the suprasternal notch were the pertinent findings. Aspiration of this lesion yielded 3 cc. of cloudy mucoid material and produced prompt improvement in ventilation. A lateral chest x-ray revealed tracheal com-



Fig. 1.—Autopsy specimen of the larynx opened posteriorly showing a large mucus-filled cyst occupying the region of the right true vocal cord (Case 1).

From the Section of Thoracic Surgery, Tampa General Hospital, Tampa. Presented at the Florida Medical Association, 93rd Annual Meeting, May 12, 1967.

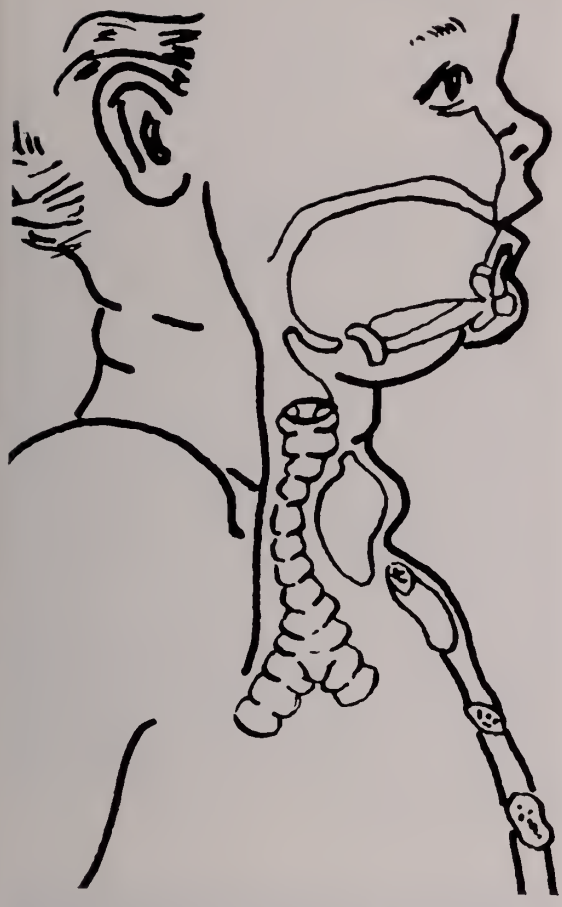


Fig. 2.—Artist's interpretation of the cystic teratoma compressing the trachea at the thoracic inlet anteriorly (Case 2).

pression at the thoracic inlet. When symptoms recurred several days later as the cyst refilled with fluid, surgical excision was effected through a low cervical incision. The lesion was easily shelled out of the surrounding tissues and proved to be a benign cystic teratoma (Fig. 2).

Intrathoracic Lesions

Intrathoracic lesions that produce respiratory difficulty usually do so by encroachment on available lung tissue, rather than by airway obstruction, as in the two preceding cases.

Pneumothorax may occur after vigorous resuscitative attempts, but spontaneous occurrence is common. Auscultation is only of limited value in this condition and the chest x-ray is the only technique that is reliable in making the diagnosis.[3]

Case 3.—An infant remained cyanotic following a full term spontaneous birth. A chest x-ray (Fig. 3) revealed an extensive bilateral pneumothorax. Insertion of a number 16 French catheter in each pleural space attached to underwater seal drainage resulted in prompt re-expansion and an uneventful recovery (Fig. 4).

Cysts or neoplasms if of sufficient size may produce respiratory embarrassment.

Case 4.—A 5 lb. 8 oz. premature infant was discharged on the third day of life as a healthy infant. Intermittent choking spells and cyanosis were noted by the mother and sudden worsening at two weeks of age prompted emergency admission. Cyanosis, tachypnea and intercostal retractions, along with absence of breath sounds at the right base, were the significant findings. Chest x-ray (Figs. 5 and 6) revealed a large mediastinal mass as well as several defective thoracic vertebrae. Prompt surgical exploration of the right side of the chest revealed a large cystic mass arising from the posterior mediastinum, attached to the thoracic aorta and middle thoracic vertebrae. Following excision, adequate lung expansion (Fig. 7) and recovery occurred. Microscopic findings proved the lesion to be a duplication cyst of the esophagus.

Overdistention of a portion of the lung may produce respiratory distress after birth. More commonly these infants get into trouble at several weeks or months of age.[5,7,9] Lobar emphysema, with or without a demonstrable bronchial abnormality, is the most common lesion producing severe symptoms and demands surgical intervention as soon as the diagnosis is established.[5,6,8,9,11]



Fig. 3.—Extensive bilateral pneumothorax is shown on this posteroanterior chest x-ray (Case 3).

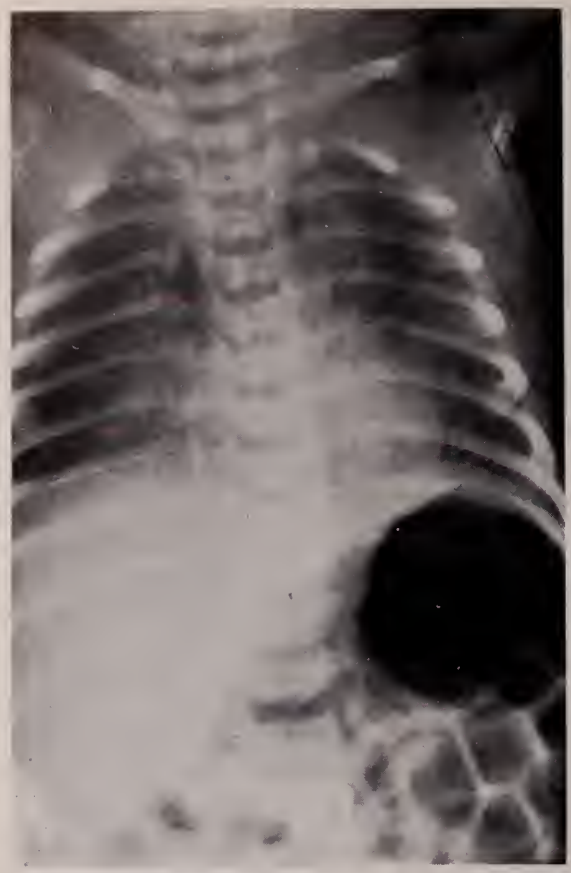


Fig. 4.—Complete re-expansion occurred following bilateral tube thoracostomy drainage (Case 3).

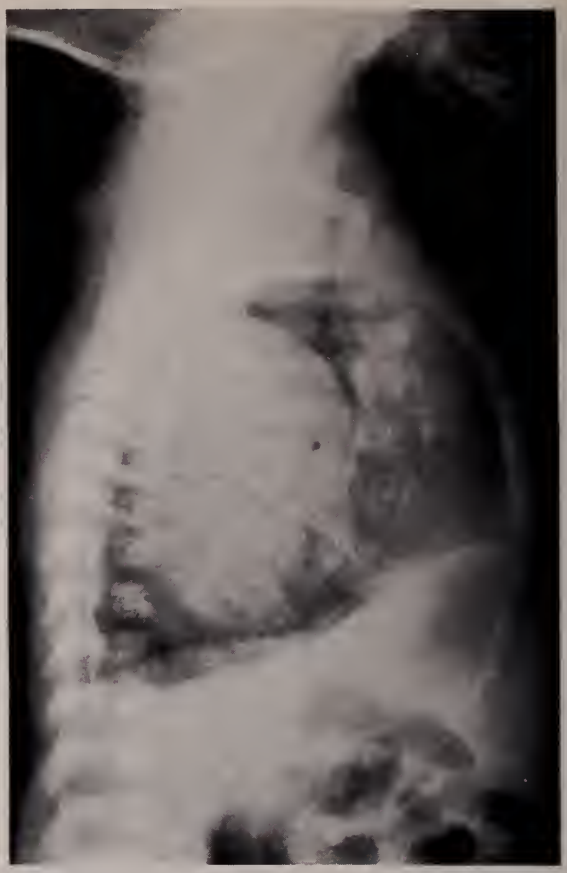


Fig. 6.—Lateral chest x-ray showing posterior location of the cyst (Case 4).



Fig. 5.—Large duplication cyst of the esophagus occupying right hemithorax (Case 4).



Fig. 7.—Postoperative chest x-ray shows adequate lung expansion (Case 4).



Fig. 8.—Large cystic lesion is evident in the right hemithorax displacing the mediastinum to the left with only a small portion of the left lung visible (Case 5).



Fig. 10.—Chest x-ray shows a multicystic lesion occupying the left hemithorax which was misinterpreted as distended loops of small intestine or colon (Case 6).



Fig. 9.—A return to a normal appearance is evident on a chest x-ray taken immediately after operation (Case 5).



Fig. 11.—Chest x-ray of the same patient several months later showing complete expansion of the remaining left lower lobe (Case 6).



Fig. 12.—Chest x-ray reveals a shift to the mediastinum in the right hemithorax with almost total opacification of the left side of the chest produced by herniated viscera (Case 7).



Fig. 13.—Barium enema helps confirm diagnosis by revealing extension of colon into left pleural space (Case 7).



Fig. 14.—Chest x-ray showing that expansion of the small left lung was partially complete by the end of three weeks (Case 7).



Fig. 15.—Chest x-ray reveals loops of bowel within right pleural space with a suggestion of a rim of diaphragm high in the right apex (Case 8).

Case 5.—A term infant had progressive respiratory difficulty several weeks following birth. Chest x-ray (Fig. 8) revealed a large cystic lesion in the right side of the chest. At operation this proved to be a cystic structure arising from the right lower lobe of the lung. Division of a rather narrow pedicle of origin effected complete expansion of the remaining lung (Fig. 9).

Case 6.—An infant began having minor respiratory difficulty shortly after birth. At three weeks of age he suddenly became intensely cyanotic with labored respiratory effort. Examination revealed decreased breath sounds over the left side of the chest and one examiner heard bowel sounds in the same area. Chest x-ray (Fig. 10) revealed multiloculated cystic areas suggesting loops of intestine to the radiologist, who made a diagnosis of diaphragmatic hernia. Abdominal exploration revealed an intact diaphragm much to the dismay of the operator.

Thoracotomy on the left side at the same operation revealed a large cystic mass which seemed to occupy the entire hemithorax. Rapid deterioration of the patient at this point prompted a compromise procedure consisting of partial excision of the cyst. Elective lobectomy of the left upper lobe several weeks later resulted in uneventful recovery with the pleural lower lobe gradually expanding to fill the remaining space (Fig. 11). The error committed in this case almost produced a fatal result. Such a case has been previously reported.[8]

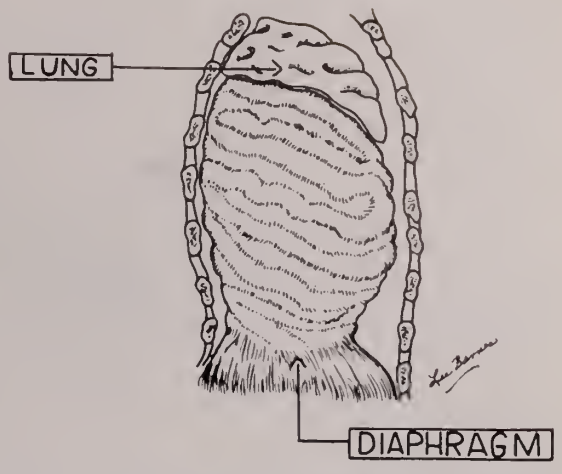


Fig. 17.—Drawing showing appearance of thinned out diaphragm containing loops of bowel (Case 8).



Fig. 16.—Lateral chest x-ray suggests diagnosis of eventration (Case 8).



Fig. 18.—Surgical repair was effected by imbrication, restoring the diaphragm to a fairly normal contour (Case 8).

Defects of the Diaphragm

Congenital defects of the diaphragm usually produce respiratory difficulties immediately following birth.[2,7,10] The most common is a defect of the foramen of Bochdalek which consists of a variable-sized opening posterolaterally in the diaphragm most frequently on the left side.

Case 7.—An infant had respiratory difficulty within the first few hours of birth and chest x-ray revealed partial opacification of the left hemithorax (Fig. 12). A barium enema demonstrated a loop of colon extending into the side of the suspected hernia (Fig. 13). An abdominal approach was utilized to effect the repair. The compressed and underdeveloped lung gradually expanded over the next several weeks (Fig. 14).

Others [2,7,10] have warned about the danger of having the anesthesiologist apply excessive pressure in an attempt to expand the small, underdeveloped lung. Judicious use of positive pressure at operation followed by tube drainage of the pleural space will usually produce expansion. Eventration of the diaphragm may remain asymptomatic, but can produce alarming symptoms in the neonate.

Case 8.—An infant appeared normal at birth and was discharged as a healthy infant several days later. Four days after returning home severe respiratory distress and cyanosis prompted emergency admission. Chest x-ray (Figs. 15 and 16) revealed loops of intestine in the right hemithorax and a diagnosis of eventration of the diaphragm was made. Immediate thoracotomy was carried out through the seventh intercostal space. Fig. 17 illustrates the appearance of the thinned-out diaphragm. Surgical repair was effected by imbrication, restoring the diaphragm to a fairly normal contour (Fig. 18).

Discussion

Any newborn having respiratory difficulties should be suspected of having a correctable surgical lesion. It is only by aggressive measures that such lesions can be diagnosed and treated promptly. Liberal use of the chest x-ray is encouraged, since many of these disorders can be diagnosed by this means alone. In addition to the causes described in the cases presented, esophageal atresia, vascular rings and cardiac anomalies can produce respiratory distress at birth and must be considered in the differential diagnosis.

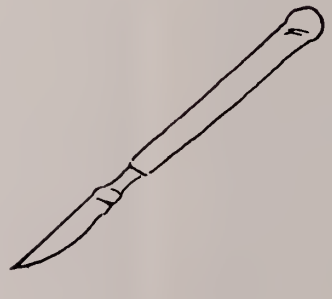
Summary

Eight cases having correctable surgical forms of respiratory distress in the newborn period are presented along with a brief discussion of each type.

References

1. Avery, M. E.: The Lung and Its Disorders in the Newborn Infant, Philadelphia, W. B. Saunders Company, 1964.
2. Cerilli, G. J.: Foramen of Bochdalek Hernia, Ann. Surg. 159:385-389 (Mar.) 1964.
3. Chernick, V., and Avery, M. E.: Spontaneous Alveolar Rupture at Birth, Pediatrics 32:816-824 (Nov.) 1963.
4. Driscoll, S. G., and Smith, C. A.: Neonatal Pulmonary Disorders, Pediat. Clin. N. America 9:325-352 (May) 1962.
5. Fischer, H. W.; Lucido, J. L., and Lynxwiler, C. P.: Lobar Emphysema, J.A.M.A. 166:340-345 (Jan. 25) 1958.
6. Fischer, H. W.; Potts, W. J., and Holinger, P. H.: Lobar Emphysema in Infants and Children, J. Pediat. 41:403-410 (Oct.) 1952.
7. Gross, Robert F.: The Surgery of Infancy and Children, Philadelphia, W. B. Saunders Company, 1953.
8. Herrmann, J. W.; Jewett, T. C. Jr., and Galletti, G.: Bronchogenic Cysts in Infants and Children, J. Thor. Surg. 37:242, 1959.
9. Minnis, J. F. Jr., and Montoya, A.: Congenital Cystic Disease of the Lung in the Newborn, Dis. Chest 41:208-213 (Feb.) 1962.
10. Snyder, W. H. Jr., and Greaney, E. M. Jr.: Congenital Diaphragmatic Hernia, 77 Consecutive Cases, Surgery 57:576-588 (Apr.) 1965.
11. Szotts, I., and Jakab, T.: Indications for Urgent Operation in Pulmonary Tension Disorders in Childhood, Arch. Dis. Child. 39:172-176 (Apr.) 1964.

▶ Dr. Blank, One Davis Boulevard, Tampa 33606.



Lidocaine As An Antiarrhythmic Agent

ROBERT B. VAN CLEVE, M.D.

Lidocaine has gained wide acceptance as a useful drug in the treatment of ventricular arrhythmias.[1-3] This paper reviews the current status of its use as an antiarrhythmic agent and emphasizes its use.

Harrison et al[4] demonstrated several advantages of lidocaine compared to procainamide in the treatment of ventricular arrhythmias. They noted that for an equivalent degree of decrease in myocardial excitability there was much less decrease of right ventricular myocardial contractile force and fall in blood pressure with lidocaine than with procainamide. Neither drug significantly affected the absolute refractory period of the myocardium. This report also stressed excellent results with the use of lidocaine in 28 patients in whom ventricular arrhythmias developed during or following cardiac surgery.

The duration of action of lidocaine is short, from 15 to 20 minutes. Its onset of action is within seconds of its intravenous injection in a dose varying from 1 to 2 mg./kg. Our working clinical dose has become an initial dose of approximately 75 mg. This dose can be repeated every two to three minutes until the desired effect is obtained. The maximum dose of this drug that can be given safely is, as yet, undetermined. There is one report in the literature of 500 mg. having been given intravenously in one hour without noted significant side effects.[4] We have used up to 2,300 mg. over a 10 hour period to suppress ventricular tachycardia, again without any effect on blood pressure or other clinical parameters. Since the effect is so transient, if long term therapy is to be used, a constant intravenous drip with up to 1,000 mg. in 200 cc. can be used. At this dosage, constant attention is required to avoid untoward reaction.

It is our current practice to use lidocaine as the initial treatment of choice in ventricular arrhythmias especially if these patients have acute myocardial infarction. We avoid procainamide and quinidine if continuous drip lidocaine is successful in the management of these arrhythmias.

Though presumably the same side effects as with procainamide could be encountered, we have not seen these in the doses mentioned with up to a total of 4 Gm. of lidocaine intravenously over a 24 hour period. Occasionally, lidocaine will have a sedative effect on the patient. In the coronary care unit in all acute infarctions, we prefer to keep lidocaine drip available as a "piggy-back" reserve at all times and, at the first evidence of premature ventricular contractions, lidocaine therapy is instituted and is titrated according to the clinical response.

We are also finding lidocaine useful as a prophylactic measure in intubation or induction

From the Department of Medicine, Riverside Clinic, Jacksonville.

of anesthesia. Though the use of lidocaine in supraventricular arrhythmias has not been widely published, we have used it on a goodly number of patients and generally found it to be ineffective except in two situations. The first occurs in patients when the differential diagnosis of ventricular tachycardia or a supraventricular tachycardia with aberrant conduction is difficult. In this instance, frequently lidocaine will help in the differential diagnosis by its effect on the arrhythmia. Also an occasional junctional tachycardia, usually due to digitalis effect, has also responded to lidocaine therapy. One caution is to be sure epinephrine is not included in the vial used for intravenous therapy.

Further clinical reports are needed for the continued evaluation of possible side effects as yet not recognized in the doses used.

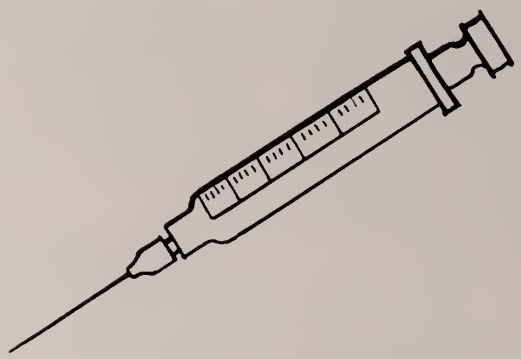
Summary

The use of lidocaine as an antiarrhythmic agent is briefly reviewed and it is suggested that this agent is now the treatment of choice for ventricular arrhythmias in the management of the acute condition and also for the maintenance over several days of therapy by intravenous drip. As yet, side effects seem to be minimal but further clinical observation is needed.

References

1. Frieden, J.: Antiarrhythmic Drugs. VII. Lidocaine as an Antiarrhythmic Agent, Am. Heart J. 70:713-715 (Nov.) 1965.
2. DeSanctis, R. W.: Electrical Conversion of Ventricular Tachycardia, J.A.M.A. 191:632-636 (Feb.) 1965.
3. Van Cleve, R. B.: Ventricular Tachycardia, Its Treatment with Emphasis on Recent Changes in Therapy, South. M. J. 60:897 (Aug.) 1967.
4. Harrison, D. C.; Sprouse, J. H., and Morrow, A. G.: The Antiarrhythmic Properties of Lidocaine and Procaine Amide, Circulation 28:486-491 (Oct.) 1963.

▶ Dr. Van Cleve, 2005 Riverside Avenue, Jacksonville 32204.



Management of Infantile Pyloric Stenosis

MICHEL GILBERT, M.D. and L. FELIPE MENCIA, M.D.

Congenital hypertrophic pyloric stenosis is one of the most common conditions requiring surgical treatment in infancy. The incidence of this dis-

See editorial comment, page 1161

ease in the United States is about one for each 300 live births.[1] We reviewed this subject to evaluate results in management and correlate preoperative signs with prognosis for the postoperative course in our patients. This report is based on 127 consecutive cases in the last five years (1961 to 1965) at the Variety Children's Hospital of Miami.

General Analysis

This disease occurs predominantly in males, 86% in our series. There is less predisposition for pyloric stenosis in Negro infants; 9% were Negro. The high incidence of this disease in first-borns is borne out by our statistics of 33% in 104 patients (23 patients did not have the information in the chart). Average age on admission was four weeks (Fig. 1). The majority of the operations were performed by three members of the surgical staff (the authors, or residents under their supervision). Private cases accounted for 75%, and 25% were staff cases.

Diagnosis

History: The most important symptom is vomiting. This is a simple regurgitation occurring a few times a day and becoming progressive until the infant vomits after each feeding. The vomiting usually becomes projectile in nature, does not contain bile and occasionally has a brownish discoloration because of blood, most likely from esophagitis. Immediately after vomiting the infants usually take the bottle avidly. Most infants had multiple formula changes prior to admission. The average age of onset of the vomiting in our series was two to three weeks. Of the infants studied, 10% started to vomit before one week of age and many had symptoms at birth. In one series the author reported 18% of his patients had vomited since birth.[2]

Decreased intake of food and fluids invariably results in decrease in frequency of stools and urination, with failure to thrive. The weight on admission in almost every instance was less than the maximal weight the infant had attained. Most of the infants either fail to gain weight properly or they actually lose weight.

Physical Examination: During feedings, and often without feedings, gastric waves may be seen passing from left to right across the epigastrium. The most important finding, which is pathognomonic of the disease in a symptomatic infant, is the palpation of a pyloric tumor. In 80% of our patients a tumor was felt preoperatively. Some examiners with a great deal of experience have been able to palpate a tumor in over 90% of affected patients.

Our technique is illustrated in Figure 2. The infant is supine. A nurse on the left side of the table feeds the infant glucose water. The examiner

From the Department of Surgery, Variety Children's Hospital, Miami.

Table 1.—Relationship Between State of Hydration and Postoperative Vomiting

Degree of Dehydration	Number of Patients	Per Cent	Postoperative Vomiters	Per Cent
Severe (over 10%)	17	13	12	71
Moderate (5 to 10%)	30	24	16	53
Mild or none (under 5%)	80	63	32	40

Of 30 patients with alkalosis, 60% had postoperative vomiting.
Of 97 patients without alkalosis, 43% had postoperative vomiting.

is comfortably seated on the right side of the examining table, supporting the flexed thighs of the infant in the right hand to relax the abdominal wall. He palpates the abdomen with the gentle use of the left middle and index finger. Too much pressure can cause subcapsular hematoma of the liver. Starting in the epigastric region, he gradually walks the fingers down to the right lumbar and umbilical area. If a gastric wave is seen, he follows it until it stops. The tumor can usually be palpated at the area where the gastric wave disappears. The tumor is usually mobile and has the shape of an olive. An inexperienced examiner may mistake a vertebral body for the tumor. Occasionally an overdistended fundus will cover the tumor and make it impossible to palpate. A number 10 Robinson catheter inserted into the stomach, and irrigation with saline to decompress it, may correct the situation. At other times the tumor may be covered by the edge of the liver and palpation will be impossible. With patience and perseverance we are of the opinion that most pyloric tumors can be felt if the infant is quietly sucking. To attempt to feel the tumor in a crying infant is a waste of time.

The state of hydration of most of these infants is a credit to the referring physicians in our area. Patients admitted with mild or no evidence of dehydration accounted for 63%, while 24% were moderately dehydrated and only 13% severely dehydrated (Table 1.) Most of the patients admitted with severe hydration were staff patients not under a physician's care before admission to the hospital.

Laboratory Work: In addition to a routine blood count and urinalysis, electrolyte studies were done in 64% of the patients. These studies were routinely done on patients who had 5% to more than 10% dehydration (moderate to severe). They were performed occasionally on infants with lesser degree of dehydration. The analysis of preoperative electrolytes in 81 patients was as follows:

12 mild alkalosis
(CO_2 29 to 31.9 mEq/per liter)
7 moderate alkalosis
(CO_2 32 to 34.9 mEq/per liter)
11 severe alkalosis
(CO_2 over 35 mEq/per liter)

Thus, 37% of 81 patients were alkalotic and 66% of patients with alkalosis had low serum chloride. It is of interest that 11 of 81 patients who had electrolyte studies were acidotic (CO_2 below 19 mEq/per liter). The serum sodium and potassium determinations were of no diagnostic value.

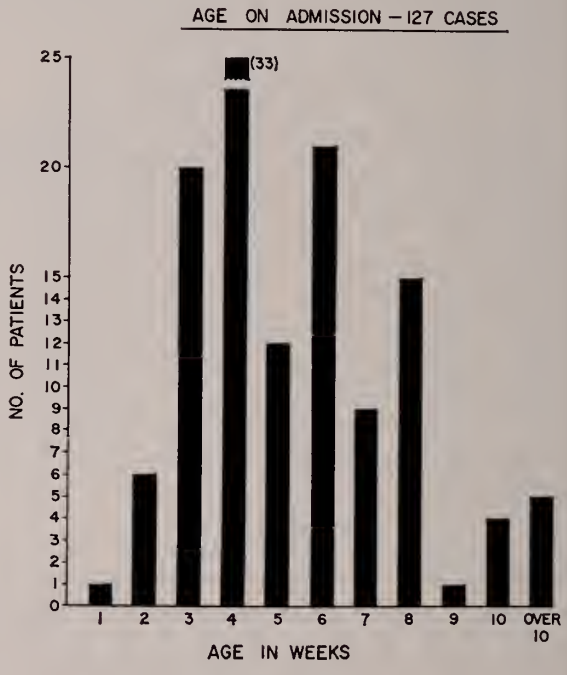


Fig. 1.—Age on admission—127 cases.

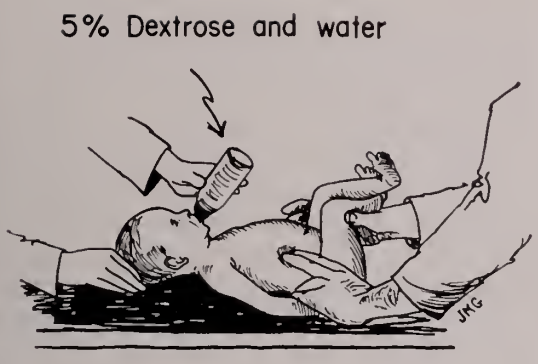


Fig. 2.—Technique for palpation of pyloric tumor.

X-ray Findings: In this series of 127 patients a gastrointestinal study was done in 73% with a palpable tumor. It was performed in all patients without a palpable tumor. Most of these patients had x-rays either before admission to the hospital or under the direction of the referring pediatrician. It is our firm belief, however, that if a pyloric tumor is palpable in a symptomatic infant, a gastrointestinal series is unnecessary. For best interpretative results, barium should be used rather than water-soluble or oily media such as Hypaque or Lipiodol. The radiologic diagnosis depends on visualization of the pyloric canal. Delayed filling of the duodenum with elongation and narrowing of the pyloric canal to a stringlike segment (Fig. 3), and evidence of compression of the duodenal bulb by hypertrophied muscles are the radiographic signs of this diagnosis.

In this series, 99 gastrointestinal series were performed with two errors in diagnosis. One patient with surgically proved pyloric stenosis had a "normal gastrointestinal series." Another patient without a palpable tumor had two gastrointestinal series done one week apart with radiographic evidence of pyloric stenosis. Upon operation, the pylorus was entirely normal. Pyloromyotomy was done with complete cessation of the vomiting postoperatively. It is of interest that one of us (M.G.) had three cases with progressive projectile vomiting where pyloric tumors were not palpated and gastrointestinal series showed definite evidences of pyloric stenosis. At operation, even though the pylorus was entirely normal, a routine Fredet-Ramstedt pyloromyotomy was done. All three patients, who had several weeks of preoperative vomiting, had no further postoperative emesis. It is our belief that spasm is the probable etiologic factor in the vomiting and the best treatment is conservative. If the condition is misdiagnosed and an operation is performed, however, pyloromyotomy should be done.

Preoperative Management

General Management: Preoperative preparation depends on the state of hydration of the patient. In our series, 66% of the patients received intravenous fluids, 8% were hydrated by mouth and 26% were operated on without any preparation. A gastrointestinal series should be done only if a pyloric tumor is not palpable. To minimize the risk of aspiration it is imperative that the stomach be lavaged with at least 200 to 250 cc. of saline to remove all milk curds and barium. Even if a gastrointestinal series is not done, the stomach should be lavaged. Serum electrolytes will be determined on most patients. A routine complete blood count and urinalysis are ordered. If the patient is minimally dehydrated (less than 5% dehydration) and electroytes normal, operation is indicated as soon as possible. Occasionally when such a patient is admitted late in the evening we will hydrate the infant, usually by the oral route, and perform a pyloromyotomy electively in the morning. During the waiting period the abdomen, especially the umbilical region, is cleaned with pHisoHex every four to six hours to minimize staphylococcus infection.

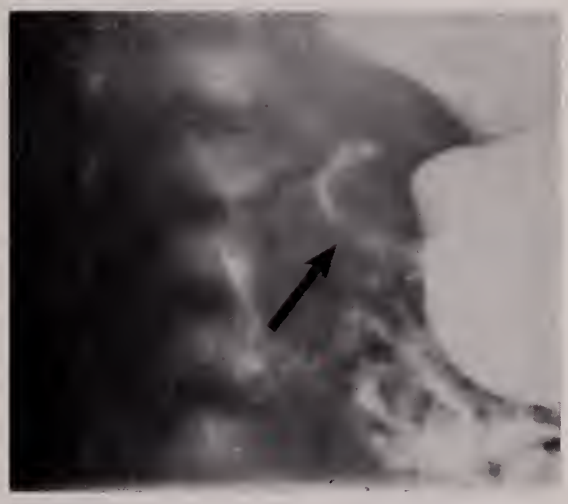


Fig. 3.—"String sign" of pyloric stenosis.

Intravenous Correction of Dehydration: When an infant was dehydrated, our average pre-

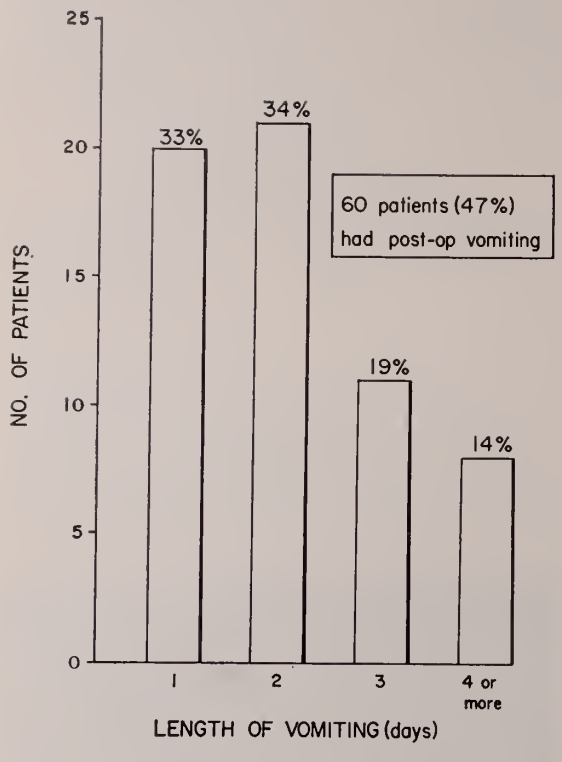


Fig. 4.—Duration of postoperative vomiting in 60 patients.

operative preparation lasted 22 hours. Some infants had to be hydrated for more than 48 hours. Others with less dehydration were ready for operation within a few hours. In all cases hydration by the intravenous or oral route was performed. Subcutaneous infusion was never used. If the infant required fluids he received 20 ml. per kg. of body weight of 5% glucose in 0.45% saline the first hour. From the second hour on, volume and electrolyte concentration were replaced according to per cent dehydration of the patient and results of the electrolyte pattern. Fluids are given on a kilogram body weight basis. The most common electrolytic disturbance seen is hypokalemic, hypochloremic alkalosis. This can be corrected with appropriate fluids containing sodium chloride and potassium. Three to four milliequivalents of potassium chloride per 100 ml. of infused fluid is added as soon as good urine output is established. Occasionally, if the patient is anemic, blood is given preoperatively. If the infant is markedly hypovolemic and in shock, plasma is given rather than saline as a starting infusion. The infant's weight is carefully recorded every 8 to 12 hours. The infant is operated upon as soon as the electrolyte pattern and skin turgor are back to normal, the urine output adequate and some of the lost weight regained.

Oral Correction of Dehydration: An instructive paper on the benefit of oral hydration in patients with pyloric stenosis[2] stimulated our group to use this method on occasion. The oral method of hydration was used with good results in 10 patients, and with poor results in three patients. Success with this method of hydration depends on particular attention to smallest details. First, the stomach is emptied of all milk curds by saline lavage. The infant is fed 2 to 3 ounces of 5% dextrose in 0.45% saline without forcing, every two hours. He should be fed in an upright position with frequent burpings. The infant is weighed before each feeding. After a period of 18 to 24 hours, hydration is usually good enough to permit a pyloromyotomy to be safely done. When the patient voids, 2 mEq. of potassium chloride is mixed in each two hour feeding. The head of the bed is elevated 30 degrees and the patient placed on his right side in the crib after feeding. All treatments and changing of diapers should be carried out prior to feeding. Three of our patients continued to vomit on this regimen, necessitating intravenous fluid therapy.

Operation

A large tube is placed in the stomach for decompression before induction of anesthesia. The infant is placed on an electrically heated mattress with the right side slightly elevated. Cyclopropane and Halothane via endotracheal tube are the anesthetic agents commonly used at this hospital. The abdomen is entered via Robertson muscle-splitting incision. To visualize the stomach, 50 ml. of air is injected through the Levin tube. Routine Fredet-Ramstedt pyloromyotomy is then performed.[3] The incision is started 1 mm. proximal to the duodenum and extended beyond the tumor into normal stomach wall. The site of incision is the most avascular area on the anterosuperior wall of the pylorus. Careful inspection for perforation of the mucosa must be made in all cases. Two helpful maneuvers are injection of air into the stomach with the pyloroduodenal area bathed in saline, and retrograde massage of the duodenum for appearance of bile. The skin is closed with subcuticular suture and collodion applied.

Postoperative Management

The Levin tube is aspirated and removed the moment the infant reacts from anesthesia. Small feedings of glucose water are started six hours after operation. If this is well tolerated, increasing amounts of evaporated milk formula are given. Usually by the third postoperative day the infant is gaining weight from fluid and caloric intake. The head of the crib should be elevated 30 degrees. After careful feeding, the infant is placed on his right side and not disturbed. All treatments, change of diapers, baths and other care are given before feeding. Vomiting can be expected the first two postoperative days. The nurse is instructed to refeed the amount vomited. Usually the second feeding is kept down.

Average stay in the hospital in the 127 patients of our series was 5.4 days because we keep premature infants hospitalized until their weight is at least five pounds. A few patients had prolonged preoperative hospitalization due to the time it took to make the diagnosis. Most of the patients were discharged by the third day of hospitalization. We believe that the best nurse is the mother herself.

Postoperative Complications

Mortality in our series was nil. We attribute this result to two factors: (1) Every patient at the time of operation was hydrated and in electrolyte balance, and (2) Management of these infants was by surgeons experienced in pediatric problems, supported by qualified anesthesiologists in an area where procedures in the younger age groups are commonplace. Four patients had wound abscess which required incision and drainage. Three patients had iatrogenic duodenal perforation recognized at operation and closed. The postoperative management of these latter patients is slightly different. They are kept on constant gastric suction and intravenous fluids for 48 hours. Antibiotics such as penicillin and kanamycin are given for a four day period. In this series there were no recurrences that required reoperation.

The most common complication was prolonged postoperative vomiting. Any patient who vomited more than twice postoperatively was placed in this group. In this series 67 patients (53%) did not vomit postoperatively; 60 patients (47%) were postoperative vomiters. Of the 60 vomiters, one third (20) stopped after the first day, another third (21) after the second day and 11 on the third day. Eight patients vomited over three days postoperatively (Fig. 4).

It is readily apparent that a high degree of preoperative dehydration is associated with more vomiting postoperatively (Table 1); 71% of patients with severe preoperative dehydration were postoperative vomiters, while only 40% of the mildly dehydrated group fell in this category. There were 30 patients with alkalosis in the series; of these, 60% were in the postoperative vomiting group. Of the remaining 97 patients without alkalosis, 43% had postoperative vomiting. This study confirms the observation of Terezis et al.[4] that one can prognosticate a higher incidence of postoperative vomiting in patients with preoperative alkalosis and/or dehydration.

Summary

A series of 127 consecutive cases of pyloric stenosis, treated by pyloromyotomy with no mortality, is reviewed. The diagnosis and management are discussed with special attention to the oral treatment of dehydration. Infants admitted with dehydration and alkalosis have a greater incidence of postoperative vomiting.

References

1. Pollock, W. F.; Norris, W. J., and Gordon, H. E.: The Management of Hypertrophic Pyloric Stenosis at the Los Angeles Childrens Hospital; A Review of 1,422 Cases, Am. J. Surg. 94:335-348 (Aug.) 1957.
2. Lynn, H. B.: The Mechanism of Pyloric Stenosis and Its Relationship to Preoperative Preparation, AMA. Arch. Surg. 81:453-459 (Sept.) 1960.
3. Gross, Robert E.: The Surgery of Infancy and Childhood: Its Principles and Techniques, Philadelphia, W. B. Saunders Company, 1953.
4. Terezis, N. L.; Sieber, W. K., and Kiesewetter, W. B.: The Prognostic Significance of Electrolyte and Weight Studies in Congenital Hypertrophic Pyloric Stenosis, Surg., Gynec. & Obst. 109:482-486 (Oct.) 1959.

▶ Dr. Gilbert, Variety Children's Hospital, Miami 33155.

Experience in Treatment of "Non Ideal" Patients With Chronic Renal Insufficiency

FELIX LO CICERO, M.D., LAWRENCE KAHANA, M.D. and ROBERT PRICE, M.D.

The so-called "ideal" patient with chronic renal insufficiency who is being considered for long term hemodialysis is required to meet certain established criteria in order to be included in such a program. These criteria, in general, are:

(1) Age
(2) Emotional stability
(3) Absence of long-standing hypertension and generalized vascular disease.

A major deterrent has been the presence of associated generalized cardiovascular disease.

The purpose of this paper is to present our experience with chronic hemodialysis in four uremic patients with generalized cardiovascular disease.

Methods

The dialysis unit at Tampa General Hospital is a large room accommodating, at the present time, three comfortable padded chairs and one bed. All equipment and drugs necessary for acute and chronic hemodialysis are stocked in the unit.

The dialyses are conducted by one of us, plus a second year medical resident who rotates through the unit, and three registered nurses who participate full time in the program.

Cannulae of the Teflon-Silastic type are inserted, revised and declotted by a general surgeon who constitutes the fourth member of our team.

Dialyses are performed by using two Kolff-Travenol dialyzers with the modification of an additional receptacle and circulator in each tank so that two patients may be dialyzed simultaneously with a common bath. Mercoid safety switches are attached to each Travenol circulator pump.

Dialyses are carried out twice weekly for the four patients. The duration of a dialysis is approximately four hours. The bath is prepared by using the Travenol Concentrate. The bath water is changed hourly. Flow rates are estimated to be between 200 and 300 cc. per minute. An adjustable clamp is applied to the venous line in order to allow for ultrafiltration and a pressure manometer is set on the bubble and clot trap to monitor the pressure within the coil.

The type of coil used depends on whether ultrafiltration is desired. The coils are first primed with heparinized saline and followed with heparinized blood. At the conclusion of dialysis the blood remaining in the coil is removed under sterile conditions into standard ACD plastic blood bags. The blood is then stored in the blood bank for use during the patient's next dialysis.

Report of Cases

Case 1.—A 58-year-old white man with a diagnosis of chronic glomerulonephritis gave a history of previous rheumatic heart disease and auscultatory findings suggested mitral insufficiency. He presented to us severely azotemic, anemic, hypertensive and with evidence of overt congestive heart failure. A Teflon-Silastic cannula was inserted in the left forearm and repeated hemodialyses were begun. He began to improve immediately and is now on a liberal protein, 4 Gm. salt diet, digitalis and

From the Renal Electrolyte Unit, Tampa General Hospital, Tampa. Presented at the 93rd Annual Meeting, Florida Medical Association, May 12, 1967.

ampicillin. His fluid intake has been restricted to 1,000 cc. per 24 hours, which he tolerates extremely well.

Case 2.—A 49-year-old white man with a diagnosis of polycystic kidneys gave a history of repeated episodes of hematuria and sustained hypertension of years' duration. One week prior to admission gross hematuria developed and was followed by progressive symptomatic azotemia and congestive heart failure. A Teflon-Silastic shunt was inserted and twice weekly hemodialyses were undertaken. He has done exceptionally well and at the present time is on a free protein, 5 Gm. salt diet with fluid intake restricted to 1,200 cc. per 24 hours. An attempt was made to increase the 24 hour fluid intake to 1,800 cc. but it was shortly followed by rapid gain in weight and evidence of congestive heart failure. This patient is currently being trained for home dialyses.

Case 3.—A 23-year-old white man with a diagnosis of chronic glomerulonephritis presented with severe hypertension and hypertensive encephalopathy. He was found to have azotemia, anemia, bilateral basilar rales, cardiomegaly and edema. The conventional antihypertensive medications produced further azotemia and the patient was then given methyldopa with some reduction in the blood pressure. Further reduction to normotensive levels and clearing of the congestive heart failure occurred after repeated hemodialyses via an internal arteriovenous side to side anastomosis.

Case 4.—A 34-year-old Negro housewife, a mother of seven, had a history of chronic pyelonephritis and hypertension of years' duration. On admission she was disoriented and manifested the full spectrum of the uremic syndrome. An attempt at moderate salt restriction to 2 Gm. led to further deterioration in renal function. A Teflon-Silastic cannula was inserted and repeated hemodialyses were begun. Marked improvement in the uremic status followed but evidence of congestive heart failure and hypertension continued. The patient would return for periodic dialysis and demonstrate rather rapid gain in weight which was attributed to a liberal fluid intake against which the patient had been repeatedly warned. The Teflon-Silastic cannulae have clotted on three separate occasions. Unfortunately, it has not been possible to remove the clots and she therefore has required revision and reimplantation of the shunts. Her left forearm now has an internal arteriovenous side to side anastomosis which will be used should the current external shunt clot.

Discussion

Congestion of the circulation is extremely common in uremic patients. This congestion is usually due to one of three mechanisms, or a mixture. First, as a sequela of hypertensive cardiovascular disease. Second, the retention of an excessive amount of administered salts in the form of diet or medications. Third, as a result of severe anemia. Our discussion will be limited to the hypertensive cardiovascular effects.

Congestive Heart Failure

The basic treatment of congestive heart failure, as the sequela of hypertensive cardiovascular disease, is well understood to include bedrest, digitalis, salt restriction and diuretics. When the cardiac decompensation is associated with chronic renal insufficiency, application of some of the measures mentioned may certainly aggravate the uremic state while still other measures may be potentially toxic.

Hyperkalemia, as a consequence of the renal insufficiency, may diminish the sensitivity of the heart to digitalis and necessitate larger doses of the drug. Should the serum potassium level then fall, as during dialysis, digitalis intoxication may ensue.

Salt restriction and diuretic therapy may produce a slow and insidious salt deficit. It has been well documented that salt restriction in normal persons and animals produces little change in renal function. The changes produced in patients with renal disease, however, are striking, and these changes are impressive regardless of the etiology of the renal disease. Glomerulofiltration rates and renal plasma flow tend to show sharp reductions with subsequent aggravation of an already existing azotemia. An average reduction of 30% in the glomerulofiltration rate occurs when salt intake is restricted in uremic patients. Caution has been stressed by Merrill in that sodium restriction is not well tolerated by patients with chronic renal insufficiency and that four to five grams of sodium chloride per day are needed by these patients. The common error of many physicians of routinely instituting a salt-free diet for patients with edema and chronic renal insufficiency is therefore to be condemned.

Hyponatremia may sometimes develop as a result of an overzealous physician's attempt to "flush out the urea." The resultant reduction in the azotemia on an obvious dilutional basis is erroneously interpreted as indicating improvement in renal function.

The management of congestive heart failure in a uremic patient is therefore unlike the routine congestive heart failure with associated renal disease. The cornerstone to successful management is fluid restriction to the degree that the patient begins to complain of thirst. During the first few weeks we noted marked changes in personality in the form of hostility as a result of the restriction, which usually amounted to 800 to 1,200 cc. per 24 hours. After this period of time, and because of the patient's own awareness of the benefits derived, the hostility disappeared.

The process of ultrafiltration during dialysis allows us to remove a calculated amount of fluid from each patient. By increasing the coil pressure, which is monitored by a pressure cuff gauge, fluid

may be removed at a rate of 2 cc. per hour for every millimeter rise in pressure. Rarely have we had to revert to increasing the tonicity of the bath water in order to remove the excess body fluid.

Hypertension

The mild and asymptomatic hypertension which is usually associated with chronic renal insufficiency should be left alone. On the other hand, symptomatic hypertension with resultant cardiovascular disease, retinopathy, or encephalopathy obviously requires therapy.

The usual measures for the treatment of hypertension frequently reduce cardiac output and renal blood flow with subsequent deterioration in renal functions. Small doses of methyldopa and/or hydralazine, in conjunction with ultrafiltration during the process of hemodialysis, are usually adequate to control the symptomatic hypertensive patient. By the process of ultrafiltration which was mentioned earlier, an average loss of four to six pounds of body fluids is achieved during a four hour dialysis if desired. By this method, maintenance of near normal tensive levels occurs, providing the patient does not gain more than one to one and one-half pounds of fluid per day. We have not had to revert to rendering our patients anephric in order to control the hypertension.

Conclusion

Successful programs in hemodialysis include selection of patients by criteria that tend to favor their success. Contrary to the experience of others, we do not believe that severe hypertension, with hypertensive cardiovascular disease, precludes chronic care on a dialysis program.

▶ Dr. Lo Cicero, 501 East Buffalo Avenue, Tampa 33603.



Classification of Inborn Errors of Metabolism Associated With Mental Retardation

CHARLES H. CARTER, M.D., DONALD CARPENTER, M.S. and
WILLIAM L. NYHAN, M.D.

In the past decade there has been tremendous progress in the recognition and understanding of metabolic disorders. Many new abnormalities are being reported every year. A large number of metabolic defects have now been described which are associated with mental retardation. In some instances, reports are preliminary in nature and serve only to alert the physician to be observant for similar conditions. In others, detailed study has been presented. Some defects are very severe and lead to early death; others are more chronic in nature, and the child may live a normal life span with retardation of some degree, frequently severe.

Some progress also has been made in the treatment of metabolic errors. In several instances, mental retardation can be prevented by early diagnosis and adequate treatment. Mass screening techniques have made early detection easier. These programs should lead to earlier diagnosis of those disorders now known, and to the recognition of others as yet unknown, particularly of milder variants of defects which in the classic case are very severe.

Many excellent discussions of metabolic errors associated with mental retardation have recently been published. The large and increasing number of these conditions has made it difficult to review adequately the entire group of them in a communication of reasonable size. The Florida Pediatric Society, through its Committee on Mental Retardation, believed that a chart which briefly outlined all of these disorders would be of value to the practicing physician. It is for this reason that this compilation was assembled. In each instance, some pertinent facts are included so that it can be used as more than a list. At the same time, it is short enough to serve as a single source of quick reference for the physician.

Some disorders in classification overlap from one group to another. It has been planned to place the condition under the classification under which the physician is most likely to look for it. As a rule, the diagnosis of each condition rests upon detection of an associated biochemical abnormality. In some instances, the enzyme defect is known and can be determined by testing. In others, the disorder is recognized by the presence of a metabolite in body fluids. Genetic implications of these disorders are in many cases not yet completely clear. The vast majority appear to be transmitted as rare recessive traits.

The chart prepared by the Committee on Mental Retardation appears on the following 11 pages.

References are available from the authors upon request.

From the Committee on Mental Retardation, Florida Pediatric Society.

▷ Dr. Carter, P.O. Box 3513, Orlando 32802.

Classification of Inborn Errors of Metabolism

DISEASE	ENZYME DEFECT	BLOOD FINDINGS	URINE FINDINGS	SIGNS AND SYMPTOMS	TREATMENT
I. AMINO AND IMINO COMPOUNDS					
1. Amines and amino acids of the urea cycle.					
a. Argininosuccinic Aciduria	Argininosuccinase	Increased ammonia, urea, increased argininosuccinic acid.	Increased argininosuccinic acid.	Mentally retarded, seizures, white hair, poor physical development, lack of pigment, increased arginino succinic acid. in spinal fluid, friable hair.	High protein diet.
b. Citrullinemia		Citrulline levels increased, increased ammonia, especially postprandially.	Citrulline increased, urea excretion normal.	Vomiting, mental and physical retardation starting at about 9 months, semicoma, convulsions.	Low protein diet.
c. Lysine intolerance with periodic ammonia intoxication.	Unknown	Arginine, lysine high, increased ammonia on any level of protein diet.		Occasional coma, spasticity, vomiting, convulsions.	Low protein diet.
d. Ornithine transcarbamylase deficiency.	Low ornithine transcarbamylase activity.	High blood ammonia.		Mental retardation, occasional coma, speech defect, headache, vomiting.	
e. Hyperlysinemia.	Unknown	High lysine even on low lysine diet.	High lysine, ornithine, ethanolamine, gamma-aminobutyric acid.	Convulsions, hypotonia, mental retardation, poor sex development, lax ligaments, physical retardation, abnormal EEG, anemia.	Low lysine diet.
f. Carbamyl Phosphate synthetase defect.	Carbamyl phosphate synthetase defect in liver.	Ammonia elevation in blood and cerebral spinal fluid, also blood glycine elevation.		Ammonia elevation in cerebral spinal fluid, vomiting, hypotonia, lethargy, chronic dehydration, mentally retarded.	Low protein diet.
g. Ammonemia	Ornithine transcarbamylase.	Increased glutamine and ammonia.	Increased glutamine.	Physical and mental retardation, high spinal fluid glutamine, and spasticity.	None
2. Sulfur Amino Acids					
a. Cystathioninuria	Absence of cystathioninase.	High cystathionine.	Elevated cystathionine.	Mental retardation, skeletal abnormalities, renal stones, one case had thrombocytopenia.	Pyridoxine
b. Homocystinuria	Cystathionine synthetase, defective metabolism of sulfur amino acids synthesis.	High plasma methionine and homocystine.	High homocystine, positive cyanide nitro-prusside test, high cystine.	Mental retardation, dislocated eye lens, vascular thrombosis, mottled skin, friable hair, malar flush, abnormal gait, absent or decreased brain cystathionine, failure to thrive, cardiovascular abnormality.	Low methionine, high cystine and cystathionine diet.
c. Cystinuria (classified by most as a disorder of transport rather than metabolism)			High cystine, lysine, arginine, orinthine due to defect in renal tubular reabsorption.	Frequent cystine stones in urinary tract, usually not retarded but may be slow, dislocation of eye lens anomaly, corneal clouding, hypotonia, physical retardation, brain may show microgyria and degeneration of myelin.	High fluid intake D-penicillamine.

DISEASE	ENZYME DEFECT	BLOOD FINDINGS	URINE FINDINGS	SIGNS AND SYMPTOMS	TREATMENT
d. Methionine malabsorption syndrome or methioninuria	Unknown	Normal amino acid pattern.	Alpha-hydroxybutyric acid high, no aminoaciduria, positive ferric chloride test, high methionine.	Convulsions, mentally retarded, hypertonia, diarrhea, white hair, edema, peculiar odor, methionine and branched chain amino acids in stool.	Low methionine diet.
e. Hypermethioninemia	Unknown	High methionine.	Aminoaciduria, high methionine.	Irritability, progressive drowsiness, abnormal odor, bleeding tendency, hepatic cirrhosis, pancreatic islet cell hyperplasia, renal tubular degeneration.	Low methionine diet?
3. Tryptophan and related Amines and Indoles					Nicotinic acid?
a. Tryptophanuria	Tryptophan pyrrolase and/or formanidase.	Increased tryptophan.	Increased tryptophan.	Dwarfism, mentally retarded, photosensitivity, ataxia, pellagra-like rash.	
b. Hartnup Disease or H-Disease	Transport of neutral amino acids, tryptophan to nicotinic acid.	Tryptophan decreased.	General aminoaciduria, especially indoles, tryptophan, indican indoleacetic acid.	Pellagra-like rash on exposed areas, photosensitivity, cerebellar ataxia, disturbance of sensorium and emotional balance, ataxia, failure of absorption of tryptophan with high fecal levels, headaches, all symptoms improve with age, nystagmus, ptosis of eyelids, mental deterioration and retardation, tremors, poor coordination, hyperactive deep tendon reflexes.	Nicotinic acid.
c. Indolylacrylyl Glycine Excretion.	Transport defect.	Normal amino acid pattern.	Elevated indolylacrylyl glycine.	Moderate mental retardation, familial.	None
d. Hyperserotoninemia	Unknown	Serotonin elevated.	None	Intermittent flushing, ataxia, seizures, retardation, emotional instability.	None
e. Pyridoxine dependency.	Glutamic acid decarboxylase.			Early convulsions, hyperirritability, hyperacusis, increased startle reflex, familial, abnormal EEG.	High Vitamin B_6 intake.
f. Kynureninase deficiency, Type 1.	Kynureninase		Xanthurenic acid elevated, also hydroxykynurenin hydroxyanthranilic acid.	Mental retardation.	High B_6 intake.
g. Blue Diaper Syndrome.	Unknown	Elevated calcium.	Elevated indican and indoles, tryptophan levels normal.	Diapers turn blue on standing, mental and physical retardation, frequent infections, irritable, constipated, excess tryptophan in feces, frequent urinary tract stones.	Low calcium, low vitamin D diet.

DISEASE	ENZYME DEFECT	BLOOD FINDINGS	URINE FINDINGS	SIGNS AND SYMPTOMS	TREATMENT
h. 3-Hydroxy-kynureninuria	Kynureninase?	None	Elevated xanthurenic acid and 3-hydroxy-kynurenine.	Stomatitis, frequent episodes of diarrhea, pellagra-like rash, mental and physical retardation.	Nicotinic acid.
i. Infantile Spasms.	Kynureninase		Xanthurenic acid elevated, also hydroxykynurenine, hydroxyanthranilic acid.	Massive myoclonic jerks, severe retardation.	High vitamin B_6 intake.
j. Kynureninase Deficiency, Type II.	Kynureninase		Xanthurenic acid in urine, elevated hydroxykynurenine.	Stomatitis, skin rash, mental and physical retardation, anemia, bony abnormalities.	High vitamin B_6 in diet.
k. Trypto-phanemia	Unknown	Increased tryptophan and leucine.	Increased tryptophan excretion.	Physical and mental retardation, hair changes, ataxia, elevated spinal fluid proteins.	Nicotinic acid?
4. Imino Compounds					
a. Hyperpro-linemia, Type I.	Proline oxidase deficiency.	High plasma proline.	High proline, hydroxyproline and glycine.	Renal hypoplasia, renal disease, deafness, mental retardation.	None
b. Hyperpro-linemia, Type II.	Pyrroline-5-carboxylate dehydrogenase.	High plasma proline.	High urine proline, high Pyrroline-5-carboxylic acid.	Convulsions, mental retardation.	None
c. Hydroxy-prolinemia.	Hydroxyproline oxidase.	High hyroxyproline.	High hydroxyproline.	Microscopic hematuria and mental retardation.	None
d. Joseph's Syndrome.		None	Increased imino acid proline hydroxyproline.	Convulsions, elevated spinal fluid protein, mental retardation.	None
e. Osteopathy, peptiduria and mental retardation.		Serum alkaline phosphatase elevated.	Glycylproline prolylhydroxy-proline elevated.	Enlarged head, thickened nose, maxilla and frontal bone, skull thick and porotic, long bones thick and bowed with much new periosteal bone, skin thick over nose and cheeks, and mental retardation.	None
5. Histidine and Related Imidazoles					
a. Histidinemia	Histidase	High histidine.	Increased histidine. Elevated imidazole-pyruvic, lactic and acetic acids: Ferric chloride-green color.	Speech defects, mental retardation.	Low histidine diet?
b. Hyper-folicacidemia	Formiminotransferase deficiency.	Hypersegmentation of tbe polymorphonuclear leukocytes, elevated folic acid and phosphorus.	Elevated formimino-glutamic acid.	Round face, obesity, physical and mental retardation, generalized edema, and convulsions.	None
c. Imidazole aminoaciduria	Unknown		Increased carnosine anserine, histidine, 1-methyl histidine.	Convulsions, cerebrovascular degeneration, blindness, mentally retarded, retinitis pigmentosa.	Unknown

DISEASE	ENZYME DEFECT	BLOOD FINDINGS	URINE FINDINGS	SIGNS AND SYMPTOMS	TREATMENT
6. Aromatic Amino Acids					
a. Phenylketonuria	Phenylalanine hydroxylase.	Phenylalanine levels over 20 mgm/100 ml, low tyrosine.	Phenylpyruvic acid and o-hydroxy phenyl-acetic acid elevated. Urine phenylalanine may be over 100 mg/ml.	Biochemical abnormalities last life time. Phenylalanine levels high soon after birth, high phenylalanine tolerance test. Patients may have seizures, eczema, peculiar odor, convulsions, hyperactivity, lack of pigment, abnormal EEG and be mentally retarded.	Special diet, low phenylalanine.
b. Atypical phenylketonuria.	Not established; some of these may lack phenylalanine transaminase or may be heterozygous for phenylalanine hydroxylase deficiency.	Phenylalanine levels over 20 mgm/100 ml but often lower than classic PKU.	Low P.P.A. and O.H.P.P.A. excretion.	Signs and symptoms not yet established but these individuals may be normal clinically.	Some require low phenylalanine diet, some a low protein diet such as human milk o Similac and some can ultimately retain a relatively normal phenylalanine level on regular diet.
c. Transient p-Hydroxyphenylpyruvic Acid—Oxidase Deficiency.	Late developing or inactive tyrosine oxidation system.	High phenylalanine and tyrosine for 3-4 months then normal for life. Phenylalanine levels usually under 20 mgm/100 ml.	Increase ρHHPA, ρHPLA ρHPAA and Tyrosine.	Usually seen in prematures condition disappears spontaneously.	Ascorbic acid, short term.
d. DOPA (Dihydroxyphenylalanine excretion).	Unknown	None	3-4-Dihydroxy-phenylalanine and creatine, DOPA high after oral loading dose.	Dwarfism, mental retardation.	High food intake
e. Tyrosinosis	p-Hydroxyphenyl-pyruvic acid oxidase.	Tyrosine high also ρHPPA ρHPLA ρHPAA, Proline, valine, leucine, isoleucine, methionine, phenylalanine.	Increased p-hydroxy-phenylpyruvic acid, tyrosine, p-hydroxy-phenylactic acid, fructose, glucose, phosphates generalized amino-aciduria.	Cirrhosis of liver, renal tubular defects, Vit.D resistant rickets, abnormal renal loss of water, hypokalemia, acidosis, glucosuria, mentally, physically retarded, abnormal EEG, seizures, vomiting, diarrhea, spasticity, thrombocythemia.	High doses of Vitamin D or diet low in phenylalanine and tyrosine
f. Tyrosinosis (Medes).	Postulated ρOHPPA oxidase.	Tyrosinemia	Increased ρOHPPA, ρOHPLA ρOHPAA.	None	None
g. Tyrosine deficiency	Tyrosine Transaminase.	Tyrosine high.	Reducing substance tyrosine.	Odd facies, microcephaly, microphthalmia, cleft lip and palate, unilateral renal agenesis.	None
h. Albinism (total).	Tyrosinase			Lack of pigment in all areas. Eye defects, occasional mental retardation.	None
i. Partial Albinism.	Same as above			Same	None

DISEASE	ENZYME DEFECT	BLOOD FINDINGS	URINE FINDINGS	SIGNS AND SYMPTOMS	TREATMENT
7. Glycine					
a. Hyperglycinemia (Glycinemia) (Glycinuria)	Unknown	High glycine in blood and spinal fluid, glycine tolerance test is abnormal.	High glycine ketonuria.	Mental retardation, neutropenia thrombocytopenia, osteoporosis, metabolic acidosis and ketosis, convulsions, deficient conversion of glycine to serine.	Restrict protein in diet, decrease leucine, isoleucine, methionine in diet.
b. Hyperglycinemia with hypooxaluria.	Unknown	High glycine.	High glycine, decreased oxalate.	Mental retardation, acidosis, vomiting, ketonuria is absent.	
c. Sarcosinemia		Elevated sarcosine.	Elevated sarcosine, ethanolamine.	Mild mental retardation.	Unknown
8. Miscellaneous Aminoacidopathies					
a. Hyper-valinemia	Unknown	Valine increased, leucine and isoleucine normal.	Valine high, leucine and isoleucine normal.	Vomiting, mental and physical retardation, lateral nystagmus, and hyperkinesia.	Low valine, leucine and isoleucine diet.
b. Maple syrup urine disease.	Oxidative decarboxylation of branched chain keto acids.	Increased branched chain amino acids leucine, valine, isoleucine and alloisoleucine.	Increased urine branched chain keto acids, ferric chloride test blue color.	Rigidity, seizures, hypoglycemia, mental retardation, maple syrup odor to body and urine.	Control branched chain amino acid intake to maintain normal serum level of each.
c. Beta-Amino-iso-butyricaciduria.	None		Increased Beta-amino-iso-butyric acid.	None	None
9. Generalized Aminoacidurias				Occurs in males, transmitted through females.	
a. Lowe's Syndrome.			Glycosuria, high pyruvic acid, aminoaciduria, organic aciduria, decreased ammonia.	Variant of Fanconi's syndrome, mental retardation, acidosis, hydrophthalmus, cataracts, rickets, hypotonia, glaucoma, areflexia, hyperactivity, vomiting and dehydration.	Vitamin D plus sodium and calcium.
b. Spastic diplegia microcephaly and aminoaciduria.			Elevated glycine alanine, threonine, serine, glutamine and glutamic acid.	Mental retardation, spastic, diplegia, epilepsy, physical retardation, optic atrophy and cerebellar hypoplasia.	None
c. Fanconi's syndrome.	Unknown disease of renal tubular function.	Early low—late high phosphorus, low calcium.	Renal failure, glucosuria, aminoaciduria, low ammonia.	Physical and occasional mental retardation, fever, vomiting, polyuria, constipation, skeletal abnormalities.	Vitamin D, potassium and sodium.
d. Cystinosis			Renal failure, aminoaciduria.	Variant of Fanconi's due probably to nephrotoxic effect of cystine. Have cystine crystals in many tissues, not usually retarded, crystals in cornea with photophobia and craving for protein foods.	Vitamin D, potassium and sodium citrate.
e. Hepatolenticular degeneration (Wilson's Disease).		Low copper, ceruloplasmin decreased.	Aminoaciduria generalized.	Abnormal copper metabolism, enlarged liver and spleen, spasticity, athetosis, ataxia, tumors, convulsions, mental retardation, deposits of copper in liver, spleen and brain nuclei, disturbed speech, fixed stare, open mouth drooling saliva, Kayser-Fleischer ring around iris and osteoporosis.	Penicillamine, low copper diet.

DISEASE	ENZYME DEFECT	BLOOD FINDINGS	URINE FINDINGS	SIGNS AND SYMPTOMS	TREATMENT
10. Biogenic Amines and Metabolites					
a. Carcinoid	5-hydroxytryptophan formation increased.	High serotonin.	High serotonin and 5-hydroxindole-acetic acid.	Physical and mental retardation, flushes of skin, vomiting and diarrhea, respiratory distress, skin rash.	High nicotinic acid intake.
b. Pheochromo-cytoma (adrenal medullary hyper-function).		Elevated catecholamines.	Glucosuria, elevated 3-methoxy-4-hydro-xymandelic acid, elevated catecholamines.	Elevated basal metabolic rate, hypertension, headaches, palpitation, vomiting, pallor, sweating, convulsions, physical and occasional mental retard-ation, genetically dominant, tumors of adrenal.	Removal of adrenal tumors.
II. Organic Acids					
1. Lactic Acid					
a. Familial lactic acidosis with necrotizing encephalo-pathy		Lactic acidosis.		Progressive ataxia, mental deterior-ation, loss of scalp hair, intermittent hypernea, progressive deterioration.	Try high doses of fluorides.
b. Familial infantile lactic acidosis.		Lactic acidosis.	Lactic acidosis.	Lethargy, hypotonia, tachypenia, mental retardation.	None?
2. Miscellaneous Organic Acids					
a. Isovaleric acidemia.		Increased isovaleric acid.	Increased iso-valeric acid.	Cherry odor to patient, vomiting, coma, episodes of acidosis, dietary intolerance to protein, mental retardation.	Low protein diet.
b. T Substance			Unknown ninhydrin reacting substance.	Mental and physical retardation.	None
c. Green acyl dehydrogenase deficiency.		Increased butyric and hexanoic acids.		Convulsions, lethargy, hepatomegaly, leukopenia, thrombocytopenia, urine, blood and breath smell stale, metabolic acidosis.	None
III. Carbohydrates					
1. Mono and Disac-charides					
a. Diabetes Mellitus.				Not usually associated with mental retardation.	
b. Essential fructosuria.				Not usually associated with mental retardation.	
c. Hereditary fructose intolerance.	Fructose-1-phosphate aldolase.	Hypoglycemia, hyper-fructosemia, elevated plasma lactic acid, free fatty acids, growth hor-mone decrease in plasma insulin and inorganic phosphorus, normal liver function tests, elevated serum bilirubin.	Fructosuria, albuminuria, ketonuria and aminoaciduria.	More severe in firstborn, failure to thrive, mental and physical retardation, vomiting, anorexia, episodes of convulsions, jaundice, hepatosplenomegaly, refusal of sweet foods, fibrosis and fatty infiltration of liver.	Fructose-free diet may improve intel-lectual development.

DISEASE	ENZYME DEFECT	BLOOD FINDINGS	URINE FINDINGS	SIGNS AND SYMPTOMS	TREATMENT
d. Galactosemia classical.	Galactose-1-phosphate 4-uridyl transferase.	Galactosemia, prothrombin deficiency, hypoglycemia, hyperchloremia, hypokalemia.	Aminoaciduria galactosuria proteinuria.	30% retarded, listlessness, vomiting, diarrhea, jaundice, hepatosplenomegaly, cataracts and convulsions.	Strict avoidance of all galactose and lactose.
e. Disaccharide malabsorption.		Lactosemia, increase in galactose-1-phosphate and lactose-1-phosphate in blood and tissues.	Aminoaciduria, proteinuria, and lactosuria.	Anorexia, vomiting, diarrhea, onset in first week of life, jaundice, physical and mental retardation, glucose and galactose metabolism are normal, autosomal recessive.	Elimination of lactose from diet.
f. Alactasia		Low serum glucose after lactose load.		Severe fermentative diarrhea, much lactic acid, glucose and galactose in stools, autosomal recessive.	Eliminate lactose from diet.
g. Malabsorption of glucose and galactose.			Deficiency of renal tubular reabsorption.	All such patients from one area of Sweden. Have severe chronic diarrhea, renal glucosuria, absence of activity of glucose, galactose and lactose, intestinal transport systems, autosomal recessive.	Give only fructose and sucrose in diet.
h. Monosaccharide malabsorption syndrome.		Flat glucose, galactose, lactose, sucrose and 3-methylglucose tolerance curves, fructose curve normal.		Acid stools, diarrhea after feeding malnutrition, growth and mental retardation, dehydration, acidosis.	Fructose-free diet produces normal growth.
i. Malabsorption of sucrose and isomaltose.		Sucrosemia (may have).		Chronic diarrhea after ingestion of sucrose and isomaltose, absence of intestinal enzymes, sucrose and isomaltose, lactic acid and sucrose in stools, sucrosuria, autosomal may be recessive or dominant.	Eliminate sucrose, isomaltose, dextrins, amylopectin, etc. from diet.
j. Idiopathic spontaneous hypoglycemia.	Unknown	Hypoglycemia, minimal fall in blood glucose after galactose.		Occurs in infancy, constant hypoglycemia with frequent convulsions and coma.	ACTH diet, occasional pancreatectomy required. Frequent feeding of carbohydrate meals, diazoxide.
k. Neonatal hypoglycemia.		Abnormal glucose tolerance test, high serum insulin.		Occurs in newborn, patients have macroglossia, hepatomegaly, omphalocele, renal hyperplasia, somatic giantism, mild microcephaly.	ACTH
l. Essential benign pentosuria.			L-xyulosuria	Not associated with mental retardation, autosomal recessive.	
m. Uridine Diphosphoglucose-glucosyl transferase deficiency, blood ferase deficiency.	No uridine diphospho-glucosyl transferase in the red blood cells.	No hyperglycemic response to glucagon.		Develop hypoglycemia after fasting, squint, convulsions, coma, liver and kidneys enlarged, autosomal recessive.	Adequate glucose intake, children appear to develop normally.

DISEASE	ENZYME DEFECT	BLOOD FINDINGS	URINE FINDINGS	SIGNS AND SYMPTOMS	TREATMENT
n. Hereditary spherocytosis.	Decreased phosphorus incorporation into ATP and 2, 3 di-phosphoglycerate.	Elevated serum bilirubin, mild anemia, spherocytes, increased osmotic fragility of red blood cells.	Increased urobilinogen.	Pallor, jaundice, cries of weakness, anorexia, vomiting, abdominal pain, enlarged spleen, thromboembolic phenomenon, rare mental retardation.	Splenectomy
o. Hereditary nonspherocytic hemolytic anemia.	Lowered glucose-6-phosphate dehydrogenase activity.	Severe red blood cell glucose-6-phosphate dehydrogenase deficiency, moderate anemia, anisocytosis, poikilocytosis, increased bilirubin.		Same as above except red blood cells are not spherocytic in shape. Have decreased glucose metabolism.	Avoid certain drugs.
p. Pyruvate kinase deficiency.	Pyruvate kinase deficiency in red blood cells, present in other tissues.	Hemolytic anemia.	Increased urobilinogen.	Hemolysis of red blood cells, anemia, pallor, jaundice, vomiting, abdominal pain, occasional mental retardation.	None
2. Glycogen Storage Diseases					
a. Type I a and b (Glucose-6-phosphatase deficiency) (Von Gierke).	Glucose-6-phosphatase absent or low in I a type; in the liver but not in I b.	Poor hyperglycemic response to glucagon or epinephrine. Galactose or dihydroxyacetone increase blood lactic acid. Prediabetic-type glucose tolerance curve. Ketoacidemia hyperlipemia, low serum inorganic phosphate.	Acetonuria	Hepatomegaly, growth retardation and rare mental retardation, hypoglycemia, ketosis, hyperlipemia, hyperlactic acidemia, bleeding, diathesis, vomiting, drowsiness, convulsions, dehydration, glycogen in liver and kidneys.	Frequent feedings, limit milk, zinc, glucagon occasionally.
b. Type II, (Pompe's)	Lysosomal acid amylo-1, 4 glucosidase.	Normal response to glucagon, epinephrine, galactose, etc.		Cardiomegaly, hypotonia, early death, cardiac failure, macroglossia, moderate hepatomegaly, mental retardation rare, prominent features as cyanosis, anorexia, tachypenia, etc. Increased glycogen in all soft tissues, glycogenosis generalized.	None
c. Type III a, b, and c, (Forbes, Cori's, limit dextrinosis)	Amylo-1, 6-glucosidase (debranching enzyme).	Hypoglycemia on fasting, hyperglycemia after glucagon feeding. Enzyme defect in white blood cells.		Hepatomegaly, muscle weakness, tendency to pulmonary infections and liver failure, no mental retardation, jaundice, occasionally other organs depend on those involved, glycogen in liver, muscle and heart.	Symptomatic
d. Type IV (Andersen's disease, amylopectinosis.)	Amylo(1,4-1,6) transglucosidase (branching enzyme).	Elevated liver function tests, poor hyperglycemic response to glycogen, some response to epinephrine, abnormal glycogen in red blood cells.		Hepatosplenomegaly, portal cirrhosis of liver, jaundice, esophageal varices, ascites, early death, mental and physical retardation, glycogen in all soft tissues.	Symptomatic
e. Type V (McArdle's disease).	Muscle Phosphorylase deficiency.	No lactic acid response to epinephrine or exercise.	Myoglobinuria	Seen in adults, have fatigability and muscle cramps after exercise, no retardation, glycogen in skeletal muscles.	Work capacity increased by high glucose or fructose intake.

DISEASE	ENZYME DEFECT	BLOOD FINDINGS	URINE FINDINGS	SIGNS AND SYMPTOMS	TREATMENT
f. Type VI (Hers disease, liver phosphorylase deficiency).	Liver phosphorylase levels below 50% of normals.	Hypoglycemia, poor hyperglycemic response to glucagon or epinephrine, good response to galactose, enzyme defect found in white blood cells.		Hepatomegaly, acidosis, physical and mental retardation, occasional dehydration, vomiting, drowsiness, may occur.	None
IV. Purines and Pyrimidines					
1. Purines					
Nyhan's disease, hyperuricemia with choreo-athetosis, mental deficiency and self mutilation.		High uric acid.	High uric acid.	Early onset of mental retardation, spasticity, choreo-athetosis, self destructive biting, all progressive in nature, probable error in purine metabolism.	Anti gout.
2. Pyrimidines					
Hereditary Oroticaciduria and megaloblastic anemia.	Absence of orotidylic pyrophosphorylase and decarboxylase activity.	Hypochromic anemia, megaloblastic bone marrow.	Increased orotic acid.	Repeated respiratory infections, diarrhea, listlessness, mental and physical retardation.	Uridine.
V. Mucopolysaccharides, Mucoproteins and Hexosamines					
1. Hurler's syndrome (Gargoylism)					
Autosomal recessive.	Unknown		Chondroitin sulfate B and heparitin sulfate excretion up.	Mental and physical deterioration, progressive, skeletal abnormalities, corneal clouding, hepatosplenomegaly.	None
b. Sex-linked recessive.			Same as above.	Same as above except no corneal clouding and patients live longer.	
c. Atypical with sporadic inheritance.			Increased heparitin sulfate in urine.	Same as #1a except no skeletal abnormalities.	
d. Adult form, autosomal recessive.			Abnormal chondroitin sulfate B in urine.	Dwarfism, corneal opacities, bony abnormalities, normal life span, little if any mental retardation.	
2. Marquio-Ullrich Diseases.			Increased keratosulfates.	Dwarfism, deformities of spine, chest, extremities, platybasia and other skeletal changes, transmitted by sex-linked recessive, rare mental retardation.	None
3. Disseminated Lipogranulomatosis.	Unknown			Irritable, hoarse cry, nodules, focus over site of trauma, mucopolysaccharide in mesenchymal cells.	None
VI. Lipids and Lipid-Like Substances					
1. Nonspecific Lipemia					
Idiopathic hyperlipidemia.		Reduced beta lipoproteins and Alpha lipoproteins, abnormal Alpha lipoproteins, elevated triglyceride levels.		Mental and physical retardation, hepatomegaly, probably an autosomal recessive trait.	None

2. Specific Lipid Disturbances					
a. Sphingolipids (Glycolipids)					
(1) Gaucher's disease, (Infantile).		Serum acid phosphatase may be elevated.		Hepatosplenomegaly.	None
(b) Gaucher's disease, (Juvenile).				Intellectual deterioration, hepatosplenomegaly.	None
(2) Niemann-Pick disease.				Hepatosplenomegaly, intellectual deterioration, myoclonic seizures, cherry-red spot.	None
(3) Tay-Sachs				Intellectual deterioration, blindness, spasticity, cherry-red spot.	None
(4) Late infantile amaurotic family idiocy.				Intellectual, visual deterioration, onset at two years of age.	None
(5) Juvenile amaurotic family idiocy.				Ataxia, intellectual deterioration, abnormal electroetinogram.	None
b. Sulfatides					
(1) Metachromatic leukodystrophy.	Arylsulfatase deficiency.			Intellectual deterioration, peripheral nerve involvement, metachromatic bodies in urine.	None
(2) Krabbe's disease, a. early infantile type, b. late infantile type.		Serum acid phosphatase levels may be elevated, plasma glycolipid levels may be low.	Blue-gray material or cells when sediment is stained with toluidine blue.	Recessive inheritance is possible, child appears normal at birth, begins to regress at 3-4 months, lives 1-3 years, has rigidity, tonic spasms brought on by noise, lateral nystagmus, occasional episodes of temperature elevation, optic atrophy, brain shows demyelination, gliosis and globoid cells, diagnosis established by brain biopsy.	None
c. Lipoproteins					
Acanthocytosis	Defective Beta-lipoprotein synthesis.			Peripheral neuritis, posterior column degeneration, retinitis pigmentosis, and mental retardation.	None
d. Lipidoses with obscure or poorly understood features (Many of these may be immune-type reactions rather than metabolic errors).					
(1) Alzheimer's disease.		Nerve cell degeneration, fresh brain weight and total lipid content greatly reduced.		Patients show sensory defects, disorientation, hallucinations, mental retardation, all progressive, seizures, tremors, transmitted genetically.	None
(2) Pelizaeus-Merzbacher disease.	Block in synthesis of cerebrosides.	Sudanophilic degeneration of myelin.		Familial in nature, sex-linked in males, onset at 6 months or earlier, have microcephaly, mental and physical retardation, and progressive spasticity.	None
(3) Schilder's disease.		Increased gamma globulin in spinal fluid with mid zone colloidal gold curve rise.		Progressive mental and physical deterioration, emotional lability, convulsions, possibly chronic viral etiology.	None
(4) Subacute Sclerosing Leukoencephalitis.		First zone colloidal gold curve rise, elevated spinal fluid gamma globulin.		Probably viral etiology, usually starts in childhood, slow mental and physical deterioration, convulsions, athetosis, spasticity, periodicity in EEG, papilledema, optic atrophy, retinitis occasionally seen.	None

DISEASE	ENZYME DEFECT	BLOOD FINDINGS	URINE FINDINGS	SIGNS AND SYMPTOMS	TREATMENT
VII. Inorganic Substances					
1. Idiopathic hypercalcemia.		Hypercalcemia, BUN elevated, gamma globulin and Alpha 2 globulin elevated.	Albuminuria	Mental and physical retardation, anorexia, vomiting, constipation, polyuria, hypotonia, elfin face, heart murmurs, hypertension, osteosclerosis, craniosynostosis, bone changes seen on x-ray.	Low calcium, low Vitamin D diet, adrenocortical steroids
VIII. Miscellaneous					
1. Muscular Dystrophies, etc.					
a. Pseudohypertrophic muscular dystrophy.		Increased serum aldolase.		Large, weak muscles, progressive in nature, varying degrees of retardation.	None
b. Facioscapulo-humeral dystrophy.				Transmission as Mendelian dominant, earlier onset, otherwise, same as above.	None
c. Mytonia Dystrophic.				Same as a. except atrophy of muscles.	None
2. Others					
a. Ataxia Telangiectasia (Louis-Bar Syndrome).	Unknown	None	Prolylhydroxy-proline increased.	Dwarfism, skin telangiectasia, cerebellar ataxia, fixed expression, drooling, speech abnormality, cafe au lait spots, degeneration of skin patches, pigmented nevi, bleeding of mucous membranes, mental retardation, deficiency in the immunological system, the gamma-l-alpha globulin is low or absent and thymus is hypoplastic.	
b. Hyperphosphatasia (probably not an entity).		Alkaline phosphatase elevated.		Pain in bones, fever, hypochromic anemia, bone deformities, rare mental retardation.	None
c. Hypophosphatasia		Alkaline phosphatase decreased, serum calcium elevated.	Increased phosphoethano-lamine.	Occasionally anorexia, vomiting, irritability, physical and mental retardation, seizures, episodes of cyanosis, respiratory infections, excess mineralization of bones, recessive.	None
d. Glutamic acidemia (probably not an entity).		Elevated glutamic acid.		Mental and physical retardation, seizures, cerebral degeneration, hair changes (sparse, coarse, blonde, brittle), spastic, early death, elevated spinal fluid, glutamic acid.	None
e. Cortical atrophy and increased glutamic acid in spinal fluid (probably not an entity).		Increased glutamic acid, proline and leucine.	Aminoaciduria, galactosuria.	Mental and physical retardation, spasticity, hyperreflexia, bilateral cortical atrophy, increased spinal fluid glutamic acid.	None
f. Familial dysautonomia.			Low creatinine, high creatine, high vanilmandelic acid, o-tyrosine.	Occurs in Jewish families, lack of lacrimation, hyperhydrosis, skin blotching, labile blood pressure, postural hypotension, erratic temperature control, emotional lability, insensitive to pain, especially eye pain, areflexia, poor coordination, abnormal histamine response, exaggerated epinephrine response.	None
g. Marfan's syndrome.	Collagen Metabolism disturbance.	Increased serum muco-protein and mucopoly-saccharides, especially keratosulfate and chon	Increase urinary bound hydroxy-proline.	Arachnodactyly, skeletal defects, lens defects, aneurysm of aorta, occasional mental retardation, atonia, very tall	None



Let's be specific about Campbell's Soups... and *reducing diets*



There are more than 30 million people in America who are overweight. During the next year, you probably will see more than 1,000 of them in your own practice.

One good way to help these patients is to give them a reducing diet based on ordinary eating patterns.

Campbell has prepared a sensible plan for weight control based on ordinary eating patterns. The plan consists of a patient instruction booklet and a set of menus which provide approximately 1,200 calories daily. The menus are balanced to provide the minimum daily requirements of nutrients.



To obtain a supply for your office write to:
Campbell Soup Company, Box 265, Camden, N. J. 08101

For the ambulant patient with hemorrho



. . . METAMUCIL®

brand of psyllium hydrophilic mucilloid

Relieves strain

Metamucil produces soft, well-formed stools that minimize pain and strain and reduce the chance of thrombosis in hemorrhoidal veins.

Softens stools

Metamucil, a highly purified vegetable colloid, absorbs water, hydrates the intestinal contents and produces a demulcent "smoothage" that aids healing of hemorrhoids and anal fissures.

Reduces pain

Metamucil reduces pain by eliminating the abrasive irritation of hard, dry stools.

Restores bowel function

Metamucil produces a gentle distention of the intestinal wall that stimulates natural peristalsis and helps reestablish normal, rhythmic bowel function.

And in constipation...

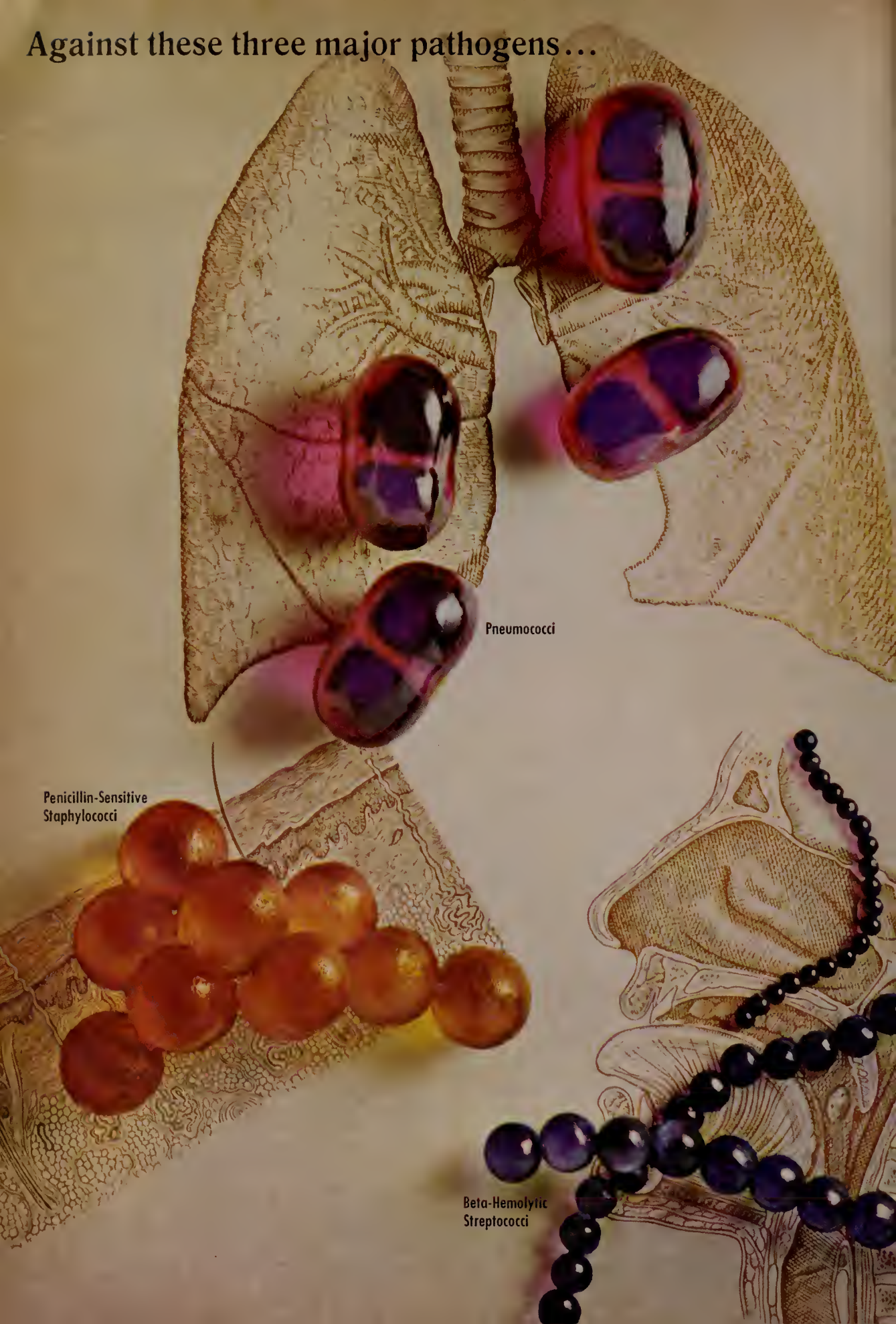
Metamucil furnishes, as it has for more than 30 years, the simple physiologic corrective to constipation, eliminating both hard stools and the need for harsh laxatives.

Usual Adult Dosage:

One rounded teaspoonful of Metamucil powder in a glass of cool liquid, or one packet of Instant Mix Metamucil in a glass of water. An additional glass of liquid is helpful.

SEARLE *Research in the Service of Medicine*

Against these three major pathogens…



V-Cillin K® provides dependable oral antibacterial therapy

because it combines a high degree of activity...

V-Cillin K has been shown to be effective in the treatment of streptococcus and pneumococcus infections as well as infections caused by sensitive strains of staphylococci. It may be used for the prophylaxis of streptococcus infections in patients with a history of rheumatic fever and for the prevention of bacterial endocarditis after tonsillectomy in patients with a history of rheumatic fever or congenital heart disease.

with high blood levels, even when taken with food

V-Cillin K is stable in acid and immediately soluble. High serum levels, therefore, are reached rapidly. Because it is acid stable, V-Cillin K is well absorbed even when taken close to mealtime. These desirable properties help make V-Cillin K a dependable penicillin for oral use.



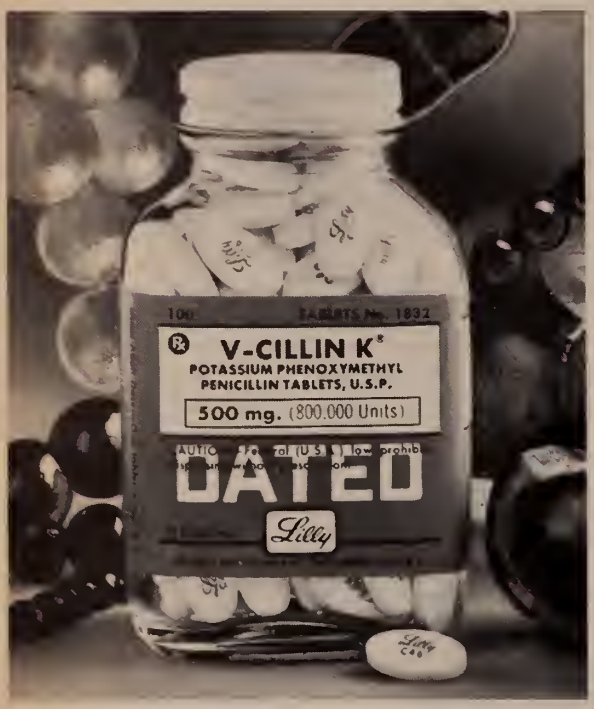
V-Cillin K® Lilly 701449

Potassium Phenoxymethyl Penicillin

Now available: V-Cillin K®, Pediatric, for Oral Solution, 250 mg. (400,000 units) per 5 cc. of solution.

(See next page for prescribing informa

New 500 mg. tablets...a more convenient way to give high doses



Description: V-Cillin K, the potassium salt of V-Cillin® (phenoxymethyl penicillin, Lilly), combines acid stability with immediate solubility and rapid absorption. Higher, more rapid serum levels are obtained than with equal oral doses of penicillin G.

Indications: Streptococcus, pneumacoccus, and gonococcus infections; infections caused by sensitive strains of staphylococci; prophylaxis of streptococcus infections in patients with a history of rheumatic fever; and prevention of bacterial endocarditis after tonsillectomy and taoth extractian in patients with a history of rheumatic fever or congenital heart disease.

Contraindication: Penicillin hypersensitivity.

Warnings: In rare instances, penicillin may cause acute anaphylaxis which may prove fatal unless promptly controlled. This type of reaction appears more frequently in patients with a histary of sensitivity reactions to penicillin or with bronchial asthma or other allergies. Resuscitative drugs should be readily available. These include epinephrine and pressor drugs (as well as oxygen for inhalation) for immediate allergic manifestations and antihistamines and corticasteroids for delayed effects.

Precautions: Use cautiously, if at all, in a patient with a strangly positive history of allergy.

In prolonged therapy with penicillin, and particularly with high parenteral dosage schedules, frequent evaluation of the renal and hematopoietic systems is recammended.

In suspected staphylococcus infections, proper labaratory studies (including sensitivity tests) should be performed.

The use of penicillin may be associated with the overgrowth of penicillin-insensitive organisms. In such cases, discontinue administration and take appropriate measures.

Adverse Reactions: Although serious allergic reactions are much less common with oral penicillin than with intramuscular forms, manifestations of penicillin allergy may occur.

Penicillin is a substance of low toxicity, but it possesses a significant index of sensitization. The following hypersensitivity reactions have been reported: skin rashes ranging from maculopapular eruptions to exfoliative dermatitis; urticaria; and reactians resembling serum sickness, including chills, fever, edema, arthralgia, and prostration. Severe and often fatal anaphylaxis has occurred (see Warnings). Hemolytic anemia, leukopenia, thrombocytopenia, and nephropathy are rarely observed side-effects and are usually associated with high parenteral dosage.

Administration and Dosage: Usual dosage range, 125 mg. (200,000 units) three times a day to 500 mg. (800,000 units) every four hours. For infants, 50 mg. per Kg. per day divided into three doses.

See package literature for detailed dosage instructions for prophylaxis of streptococcus infections, surgery, gonorrhea, and severe infections.

How Supplied: Tablets V-Cillin K, U.S.P., 125 mg. (200,000 units), 250 mg. (400,000 units), and 500 mg. (800,000 units).

V-Cillin K, Pediatric, for Oral Solution, 125 mg. (200,000 units) and 250 mg. (400,000 units) per 5 cc. of solution (approximately one teaspoonful). [042567]

Additional informatian available to physicians upon request. Eli Lilly and Campany, Indianapalis, Indiana 46206.

Lilly

701449

Editorials



Let There Be Light

"Let there be light," the first Divine fiat found in Scripture, is also a primary desire of man. Fear of darkness and all the unknown hidden within it was probably one of the earliest and most pressing of man's experiences. Primitive man's complete dependence upon the natural forces for illumination is reflected in early folk festivals still revealed in current religions. Thus both Judaism and Christianity observe festivals seasonal in nature with ceremonies which reveal their earlier origins. The Jewish holiday of Chanukah is observed by the lighting of candles in the home for a period of eight days; a prominent role is played by the burning of candles and of the yule log on Christmas. Both holidays fall on or near the time of the winter solstice.

But the need for light extends beyond the purposes of illumination in time and space. Life itself, the nature of man—the physical, psychological being—all cry out for greater knowledge and understanding. As science and faith have gone forward courageously lighting the way and as the illumined area becomes greater and greater, we realize even more than did our predecessors not only the need for maintaining the light that we have but also the necessity for hastening forward lest the darkness itself overtake us. Man, with scientific discoveries undreamed of at his command, can destroy his creations and himself. "Let there be light" to illumine human nature to permit us to soar out into spiritual space and to pioneer those patterns of thinking and living that will lead to a better world. May this season of light direct us to that goal.

Rev. Dr. Sidney M. Lefkowitz, Rabbi
Congregation Ahavath Chesed
Jacksonville

Editor's Note: This is the seventh in a series of invited guest editorials appropriate to the season by leading ministers and rabbis published in the hope that physicians will find these messages a source of guidance and inspiration.

T.M.

Tomorrow's Hospitals – Today

A physician friend, convalescing from coronary thrombosis recently in the intensive care section of Duke Hospital, watched his electrocardiographic tracing on the monitor tube—and saw it suddenly flatten out with cardiac arrest. Fortunately for him, a trained resuscitation team was at hand and he lived to tour Europe six months later. No such happy outcome would have been possible in perhaps the larger proportion of today's hospitals. In all except a few, intensive care units are makeshift, added-on facilities, inadequately staffed and largely ineffective. In fact, a brand new 400 bed hospital, opened two months ago in a large Eastern city, has no intensive care unit at all.

Fortunately for the seriously ill, new concepts of medical care are being put into effect in at least two parts of the North American continent

and hospitals are now under construction in which two essential truths are pre-eminent: first, that the care of the seriously ill patient takes precedence over everything else, and second, that such care can be most effectively given in a separate hospital unit geared to the needs. One of these hospitals, at this stage a large excavation in the midst of the Georgetown University Medical Center, owes its being to one man, research pathologist Dr. Charles F. Geshickter. The other, located at Edmonton, Alberta, in Canada, is largely a product of the systems analysis genius of highly trained engineers and scientists of TRW, Inc., a major contributor to the success of America's space program. In their planning and singleness of purpose, these two hospitals of tomorrow embody principles so new and revolutionary in concept that every hospital planner today should study them closely.

The gravest problems in medical care—which for the seriously ill can only mean hospital care—are cost and personnel; while the first is soaring, the supply of the latter, particularly skilled doctors and nurses, is in ever shorter supply. And since humans cannot be manufactured, they must be replaced in the only possible way, by automation. A multiple differential analyzer that does the work in blood chemistry formerly requiring 10 technicians is obviously a profitable investment for any large hospital laboratory. Even more profitable is a computer that can supply record data for instant retrieval, route medicines in specific doses and pre-packaged diets directly to the patient, keep most of the nurses' records, maintain a continuous electronic watch over vital functions and warn of any major change—and bill the entire cost of services at discharge, even charging the patient's account at the bank. More mundanely, a conveyor belt for speeding supplies to nursing stations and laundry in the other direction can save thousands of costly man-hours.

In tomorrow's hospital all these and many other functions will be carried out by automation. Fully 90% of medical histories can be taken by trained interviewers, saving medical personnel; routine work-ups, recorded by computer, can precede admission and even the clinical observation of the patient can be much more efficiently carried out in most instances by the marvelously sophisticated monitors developed for watching over astronauts in space than by the doctor hurriedly making ward rounds once or twice a day and ever conscious of an office filled with patients. Even the passage of human traffic through corridors can be speeded up remarkably by the techniques of systems analysis applied to hospital construction.

No longer can hospital architects excuse antiquated facilities as "what the doctors ordered." True, a doctor in Georgetown is largely responsible for one of the two most modern facilities now being constructed, but he did it only after many months of study and consultation with experts. The average doctor is no more qualified to plan tomorrow's hospital than he would be to predict the future 10 years from now; that job should be left to experts in automation and space-age instrumentation, with only secondary consideration for the comfort of the staff doctor.

In the final analysis, tomorrow's hospitals are being built around one essential theme, that their function is the care of the sick who lie under the threat of death. Other care, convalescent or domiciliary, can usually be carried out in existing facilities where no such concentration of trained, expensive personnel and equipment is necessary. This means that an entire section, preferably a new building and almost of necessity a high-rise type of structure with its central bank of elevator and service facilities and its outer ring of rooms fully visible at all times from the nursing station, must be devoted to the one purpose of saving a life, in the period of seconds that can reduce the victim of cardiac arrest to a human vegetable from lack of oxygen. In fact, having the seriously ill and the convalescent on even the same floor will soon be a breach of the best principles of medical care as surely as was the transmission of infection from the anatomy laboratory to women in labor by the students of Semmelweis over a hundred years ago.

Tomorrow's hospitals are in the construction stage today; hospital architects and planners who do not study them before another line is drawn or another brick laid are dooming their brand new structures to the fate of being antiquated before they are dedicated.

Frank G. Slaughter, M.D.
Jacksonville

Editors Note: This is the fifteenth consecutive year the Journal has published a guest editorial in December by Dr. Slaughter, Florida's distinguished physician-author.

Respiratory Distress in the Newborn

"Surgical Conditions Producing Respiratory Distress in the Newborn" in this issue of the Journal is an interesting and rewarding report.

See scientific article, page 1130

I continue pleased and convinced that medical literature is not solely the field of the researcher and teacher, but can be made more practicably informative for the physician in practice who is willing to record what he or she is doing, as well as how, when and where.

A high index of suspicion is a very worthwhile trait in pediatricians. Without it these cases could very well have been delayed in diagnosis and treatment, which would have been catastrophic. The authors stress utilization of x-ray, which is certainly not to be challenged. I would like to stress simple, careful and enlightened observation and examination. These will lead to correct presumptive diagnoses in many of these cases and will direct the course of study and treatment in the proper channels. I might point out that complete reliance on x-rays, as excellent as they are in present times, led the operating surgeon astray in one of the cases presented. Were there bowel sounds present in the chest, or rather, did anybody listen for them?

James M. Weaver, M.D.
Fort Lauderdale

Infantile Pyloric Stenosis

Hypertrophic pyloric stenosis, one of the classical surgical conditions in pediatrics, is the subject of an excellent review appearing elsewhere in

See scientific article, page 1139

this issue of the Journal. The high incidence of this disease, and thereby its importance in any pediatric practice, is emphasized in the report by Doctors Gilbert and Mencía. In spite of the high frequency of its occurrence, however, pyloric stenosis remains one of the most singular conditions in surgery. Rarely does a surgical operation devised for a specific condition withstand the trials of 60 years without significant alteration. Such is the case though with pyloromyotomy as described independently by Doctors Fredet and Ramstedt in 1907 and 1912 respectively. The utter simplicity and logic of this procedure account, I believe, for its spectacular success. Little comment need be made, then, regarding technical considerations in managing pyloric stenosis. Most of the clinical discussion about this condition centers around the nonoperative aspects—namely diagnosis and preoperative and postoperative care. Little unanimity of opinion will be found among surgeons, or among pediatricians for that matter, regarding the specific details of these particular areas of management. I am sure, however, that in those instances where conscientious and informed physicians are involved in the care of these infants, the end result of their management will be the same. The methods of achieving these end results are therefore less important than the degree of interest and dedication used in administering them. These latter factors are certainly well in evidence in the series reported herein by Doctors Gilbert and Mencía.

I would support the authors strongly in their contention that most pyloric tumors can be palpated if the proper technique and a sufficient amount of patience are used. I personally examine the child from the opposite side from that recommended, but there again, the method is not so

Synirin®

ACETYLSALICYLIC ACID (ASPIRIN)..... 5 GR.
*PENTOBARBITAL (ACID)..... 1/8 GR.
*Warning: may be habit-forming

Synirin provides prompt barbiturate potentiation of aspirin without limiting the therapeutic usage of aspirin. Both pentobarbital and aspirin begin their action together promptly and last 4 or 5 hours. There is no accumulation.

LITERATURE AND CLINICAL SUPPLY AVAILABLE TO PHYSICIANS

SYNIRIN is another pharmaceutical achievement

WM. P. POYTHRESS & CO., INC.
RICHMOND, VIRGINIA 23217
Manufacturers of ethical pharmaceuticals since 1856

important as the patience and perseverance used in its application.

Having made the statement that almost all pyloric tumors can be palpated, the next statement then logically follows. Barium contrast studies are almost never necessary to diagnose pyloric stenosis. Since the presence of a palpable pyloric tumor is pathognomonic for the disease, it seems not only a waste of time and the family's financial resources but also an unnecessary risk because of the dangers of aspiration and other operative and postoperative problems associated with the presence of barium in the gastrointestinal tract.

Many other areas of current debate can be pointed out, including methods and amounts of fluid and electrolyte replacement and the rapidity and type of postoperative feeding. As far as fluid and electrolyte replacement is concerned, the intravenous route is the most widely used, and rightly so. It is the quickest and most accurate way of replacing calculated or estimated deficits, though care must be exercised and precautions taken that the infant's circulation not be overloaded. The use of the oral route for preoperative replacement has not been used widely in this country, probably more because of its uncertainty than for its requirements for more meticulous management. This regimen, however, has been carried a step further by the Scandinavians, who treat a majority of infants in this fashion, not for preoperative preparation but as an alternative to surgery. The process takes sometimes several weeks, however, making it a wearisome and economically burdensome endeavor. The fact that it can be accomplished at all, though, demonstrates that pyloric stenosis is a reversible and potentially self-limiting disease.

Early postoperative feeding following pyloromyotomy is "in" in this country. I have heard, as I am sure most surgeons have, various institutions vying for the honor of who can feed their infants the earliest. I happen to be in the minority in this respect, but I am firmly convinced that the initiation of feeding earlier than 12 hours is of

no benefit and potentially of considerable danger. Some recent unpublished studies have shown that there is no return of gastric peristalsis within the first 12 hours following surgical intervention; therefore, any ingested feeding will merely lie inert or be regurgitated anyway—so why give it in the first place? Postoperative vomiting is inevitable in some, but by no means should it be accepted as routine.

The most challenging aspect of the whole problem of pyloric stenosis lies undoubtedly in its obscure etiology. It is surprising, in view of the large volume of literature about this condition, how little has been dedicated to original research about its cause. Many related questions remain unanswered. Why does it occur exclusively in this age group, for example? Why is there a high familial incidence? Why does the "tumor" disappear rapidly after operation, provided it is successful? I have seen one instance where the "tumor" remained palpable. The infant continued to vomit and required a second pyloromyotomy. No one has a satisfactory answer to any of these questions. Belding and Kernohan and Friesen have implicated the local neuromuscular apparatus as being deficient in some fashion although others do not agree. Certainly there is no consistently demonstrable paucity or defect of the ganglion cells in the pylorus. The key word, however, is "demonstrable," for perhaps the defect is not one which is demonstrable by our present methods. It is my belief that advanced histochemical techniques will ultimately depict the abnormality for us and that quite likely it will reside in the neurohumoral realm.

As a last word, I would second the authors' praise for their referring physicians. We are also well blessed in our area. Practically never do we see the severe alkalosis and inanition which at one time were the hallmarks of pyloric stenosis. There is always room for improvement in early diagnosis, but the ability of these physicians to ferret these infants out of the large numbers of vomiters and "spitters" which they see is to be commended.

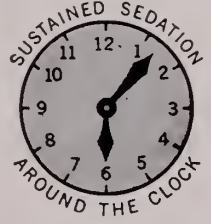
H. Warner Webb, M.D.
Jacksonville

removes the mental blur

that clouds vision

SOLFOTON®

Each tablet or capsule contains
PHENOBARBITAL.....16 mg.
(Warning: may be habit forming)
BENSULFOID® (See P D R).....65 mg.
Precaution: same as 16 mg. of phenobarbital



Constructive Therapy
A Solfoton tablet or capsule at 6 hour intervals maintains sedation at the threshold of calmness, sustaining a mental climate for purposeful living.
Literature and clinical samples sent upon request.

FEDERAL LAW PROHIBITS DISPENSING WITHOUT PRESCRIPTION

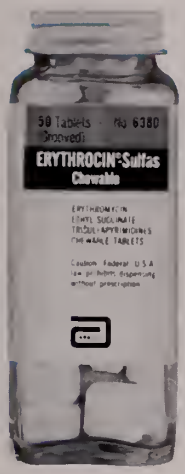
AVAILABLE
Solfoton *(yellow, uncoated tablets "P")*
100s, 500s, 5000s
Solfoton Capsules *(yellow and brown)*
100s, 500s, 1000s
Solfoton S/C *(sugar-coated beige tablets)*
100s, 500s, 4000s

WM. P. POYTHRESS & CO., INC.
RICHMOND, VIRGINIA 23217
Manufacturers of ethical pharmaceuticals since 1856



Perhaps there have been times when you wanted to prescribe erythromycin and triple sulfas for little patients. Now you can—with a choice of two new fine-tasting pediatric forms.

New–Two Pediatric Forms of Erythromycin and Triple Sulfas





ERYTHROCIN®-SULFAS Chewable (Erythromycin ethyl succinate-trisulfapyrimidines chewable tablet)

In clinical trials[1,2], this orange-flavored tablet was given to 55 patients, aged four months to 18 years.

Diagnoses (multiple in some cases) represented a cross section of bacterial infections commonly seen in pediatric office practice.

Therapy was given from three to 12 days, with an average of six days.

Of the 55 patients, 30 were reported cured within 72 hours, while 22 showed partial recovery within the same time, and subsequent clinical cure.

A clinical cure rate of 94.5%

ERYTHROCIN®-SULFAS Granules (Erythromycin ethyl succinate-trisulfapyrimidines granules for oral suspension)

87 patients were treated[1,2]—all children, ages four months to 15 years.

The diagnoses were multiple in some cases and were chiefly bacterial infections of the respiratory tract.

Dosage was maintained from three to 10 days; average treatment was five days. All of the ill children accepted the orange-flavored suspension favorably.

53 were clinically cured within 72 hours, while 32 showed partial relief within the same time, and subsequent clinical cure.

701358

A clinical cure rate of 97.7%

1. Case Reports on File, Dept. Clin. Development, Abbott Laboratories.
2. Polley, R.F.L., Use of Erythromycin-Sulfas in Office Practice, Western Med., 7:177, July, 1966.

ABBOTT

Brief Summary on next page

ERYTHROCIN®-SULFAS
Brief Summary

Contraindications: Known sensitivity to erythromycin or sulfonamides. Because of the possibility of kernicterus with sulfonamides, do not use in pregnancy at term, premature or newborn infants.

Warnings: As with other forms of sulfonamide therapy, carefully evaluate patients with liver or kidney damage, urinary obstruction, or blood dyscrasia. Deaths have been reported from hypersensitivity reactions and blood dyscrasias following use of sulfonamides. Perform blood counts and liver and kidney function tests if used repeatedly at close intervals or for long periods.

Precautions, Side Effects: Occasionally mild abdominal discomfort, nausea or vomiting may occur with erythromycin, generally controlled by reduction of dosage. Mild allergic reactions (such as urticaria and other skin rashes) may occur. Serious allergic reactions have been extremely infrequent. Use sulfonamides with caution in patients with a history of allergy. Assure adequate fluid intake to prevent crystalluria and institute alkali therapy if indicated. If overgrowth of nonsusceptible organisms occurs, withdraw the drug and institute appropriate treatment. If a patient should show signs of hypersensitivity, appropriate countermeasures (e.g. epinephrine, steriods, etc.) should be administered and the drug withdrawn.

Adverse Reactions: Sulfonamide therapy may be associated with headache, nausea, vomiting, urticaria, diarrhea, hepatitis, pancreatitis, blood dyscrasias, neuropathy, drug fever, skin rash, injection of the conjunctiva and sclera, petechiae, purpura, hematuria and crystalluria.

Side effects due to erythromycin are infrequent, but occasional abdominal discomfort, nausea, or vomiting, urticaria and other skin rashes may occur.

Supplied: The Granules for Oral Suspension come in bottles of 60 ml. and 150 ml. The Chewable tablets are in bottles of 50. Each 5-ml. teaspoonful of reconstituted Granules or each Chewable tablet provides erythromycin ethyl succinate equivalent to 125 mg. of erythromycin activity and 167 mg. of each of sulfadiazine, sulfamerazine and sulfamethazine.

701358

ABBOTT

CONVENTION PRESS

2111 NORTH LIBERTY ST.
JACKSONVILLE, FLORIDA
32206

QUALITY BOOK PRINTING
PUBLICATIONS BROCHURES

WHATEVER your first requisites may be, we always endeavor to maintain a standard of quality in keeping with our reputation for fine work — and at the same time provide the service desired. Let CONVENTION PRESS help solve your printing problems by intelligently assisting on all details.

A COMPLETE BUSINESS SERVICE

FOR THE MEDICAL AND DENTAL PROFESSIONS

Professional Management

PM FLORIDA

233 Fourth Ave, N.E.
St. Petersburg, Florida
Phone 898-5074

1855 Hillview Street
Sarasota, Florida
Sarasota Phone 958-4493
4771 Bilmark
Ft. Myers, Florida
Ft. Myers Phone 936-3162

PROFESSIONAL MANAGEMENT FOR PHYSICIANS AND DENTISTS since 1932 PM

417 Executive Building
1175 N.E. 125th St.
Miami, Florida 33125
Dade Phone 751-2101
Broward Phone 523-0286

Affiliates of Black & Skaggs Associates
Battle Creek, Michigan

DORSEY "FLU-GRAM"

DON'T BE LULLED BY RELATIVE LACK OF FLU LAST WINTER. THIS WINTER BE PREPARED: WHEN THE COMPLAINTS ARE COUGH AND CONGESTION, YOU CAN RELIEVE THESE SYMPTOMS WITH TUSSAGESIC TABLETS. ONE TIMED-RELEASE TABLET AT MORNING, MIDAFTERNOON AND BEDTIME BRINGS UP TO 24 HOURS' RELIEF FROM TROUBLESOME COUGH AND STUFFED AND RUNNY NOSE. TUSSAGESIC IS THE FAMOUS TRIAMINIC FORMULA, PLUS THREE OTHER PROVED CONSTITUENTS. MAKES PATIENTS MORE COMFORTABLE. FAST. ASK YOUR DORSEY REPRESENTATIVE FOR SUPPLY OF STARTER SAMPLES, OR IF FLU IS ALREADY EPIDEMIC, PHONE COLLECT. SEE BELOW.

each

Tussagesic®

timed-release tablet contains:

Triaminic® (phenylpropanolamine hydrochloride 25 mg., pheniramine maleate 12.5 mg., pyrilamine maleate 12.5 mg.)	50 mg.
Dextromethorphan hydrobromide	30 mg.
Terpin hydrate	180 mg.
Acetaminophen	325 mg.

Dosage: Adults—1 tablet, swallowed whole to preserve timed-release feature, in morning, midafternoon and at bedtime. Side effects: Occasional drowsiness, blurred vision, cardiac palpitations, flushing, dizziness, nervousness or gastrointestinal upsets. Precautions: The patient should be advised not to drive a car or operate dangerous machinery if drowsiness occurs. Use with caution in patients with hypertension, heart disease, diabetes or thyrotoxicosis.

DORSEY LABORATORIES
a division of The Wander Company
Lincoln, Nebraska 68501

clip and file under "flu"

For relief of "flu-like" symptoms
Tussagesic timed-release tablets

PHONE COLLECT

For emergency starter samples
to Keith Sehnert, M.D.
Medical Director
(402) 434-6311

Fast delivery by your Dorsey
Representative



when he just can't sleep

Tuinal®

One-Half Sodium Amobarbital and
One-Half Sodium Secobarbital
supplied in ¾, 1½, and 3-grain Pulvules®



Tuinal helps wakeful patients fall asleep fast, stay asleep all night.

Indications: Tuinal is indicated for prompt and moderately long-acting hypnosis. It is not suitable for continuous daytime sedation.

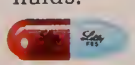
Contraindications: Barbiturates should not be administered to anyone with a history of porphyria, nor should they be given in the presence of uncontrolled pain, because excitement may result.

Warning: May be habit-forming.

Precautions: Tuinal should be used cautiously in patients with decreased liver function, since prolongation of effect may occur.

Adverse Reactions: Idiosyncrasy, such as excitement, hangover, or pain, may appear. Hypersensitivity reactions occur in some patients, especially in those with asthma, urticaria, or angioneurotic edema.

Overdosage: C.N.S. depression. Symptoms—Depression of respiration and of superficial and deep reflexes, slight constriction of the pupils (in severe poisoning, dilation), decreased urine formation, lowered body temperature, coma. Treatment—Symptomatic and supportive (gastric lavage; intravenous fluids; maintenance of blood pressure, body temperature, and adequate respiration). Dialysis may speed removal of barbiturates from body fluids.



Dosage: 50-200 mg. (¾-3 grains) at bedtime.

[031767]

Additional information available to physicians upon request.
Eli Lilly and Company • Indianapolis, Indiana 46206

700955

Lilly

DIARRHEA



CANTIL®
(mepenzolate bromide)

Diarrhea, one of the most vexing symptoms of common G.I. disorders can often be curbed with Cantil (mepenzolate bromide), bringing welcome relief to the harassed patient. Relatively specific for the hyperactive colon, it helps reduce diarrhea, pain and spasm with minimal effect on other viscera. Cantil (mepenzolate bromide) is indicated whenever these symptoms are associated with irritable colon, gastroenteritis, diverticulitis, and mild to moderate ulcerative colitis.

It is an anticholinergic drug without narcotic properties. Side effects are usually mild.

LAKESIDE

IN BRIEF: One or two tablets three times a day and one or two at bedtime usually provide prompt relief. Cantil with Phenobarbital may be prescribed if sedation is required.

Dryness of the mouth, blurring of vision, constipation, nausea, vomiting, bloating and dizziness may occur but are usually mild and transitory. Urinary retention is rare. Caution should be observed in prostatic hypertrophy — withhold in glaucoma. Contraindicated in patients sensitive to phenobarbital and/or Cantil (mepenzolate bromide); in toxic megacolon, obstruction of G.I. or G.U. tract.

SUPPLIED: CANTIL (mepenzolate bromide) — 25 mg. per scored tablet. Bottles of 100 and 250. CANTIL with PHENOBARBITAL — containing in each scored tablet 16 mg. phenobarbital (warning: may be habit forming) and 25 mg. mepenzolate bromide. Bottles of 100 and 250.

LAKESIDE LABORATORIES, INC., Milwaukee, Wisconsin 53201



Others Are Saying

Legislative Report

To: Fellow members of the Duval County Medical Society

I wish to take the opportunity of the termination of the regular legislative session of the 1967 Legislature to forward each of you a report upon our experiences in the Senate. There was one other physician, a neurosurgeon from Ft. Lauderdale, Dr. David Lane, who served with me in the Senate. Representative Walter Sackett, in general medicine, from Coral Gables, and Representative Richard Hodes, an anesthesiologist from Tampa, served in the House.

I believe each one of us was ever cognizant that, as the first physicians elected in the past quarter of a century to the Legislature, we were under particular scrutiny. It was the goal of each of us to maintain the dignity of our profession without allowing such to result in the appearance of complete political naiveté or lack of effectiveness.

Each of us maintained good contact with the lobbyist-representatives of the Florida Medical Association and with those physicians representing the legislative branch of our state association, Dr. Ed Haskell of Tallahassee in particular.

We were able to get almost the entire packet of the desired legislation proposed by the Florida Medical Association through the Senate. Not all of this was successful in clearing the House hurdle; however, in deference to the physician-Representatives, these pieces of legislation reached the House at a later point in the session, when consideration was sometimes on political grounds rather than on the merits of the legislation presented.

In addition, we were instrumental in helping get through much legislation for our para-medical groups, and also were able to shape legislation in the health field in areas wherein medicine is only indirectly affected.

I should like to take this opportunity to thank publicly my medical associates, James W. Hendrick, M.D., A. Garland Jonas, Jr., M.D. and Gerald M. Platock, M.D., for assuming so cheerfully the extra burden this public service entailed upon them, and to express my appreciation again to the members of the Duval County Medical Society for their confidence and trust in backing my campaigns of the past year.

I wish to solicit criticism from any member as to where I might have done wrong, suggestions for improvement in the conduct of my office, and any ideas that might serve as the subject of proposed legislation in the future.

Yours very sincerely,

JOHN J. FISHER, M.D.
SENATOR, DISTRICT 10

Reprinted from the Duval County Medical Society Bulletin, September 1967.

If it doesn't work in a week, forget it.

Contraindications: Edema; danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. The drug should not be given when the patient is senile or when other potent drugs are given concurrently. Large doses of Butazolidin alka are contraindicated in glaucoma.

Warning: If coumarin-type anticoagulants are given simultaneously, watch for excessive increase in prothrombin time. Instances of severe bleeding have occurred. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea, sulfonamide-type agents and insulin. Carefully observe patients receiving such therapy. Use with great caution in the first trimester of pregnancy.

Precautions: Before prescribing, carefully select patients, avoiding those responsive to routine measures as well as contraindicated patients. Obtain a detailed history and a complete physical and laboratory examination, including a blood count. The patient should not exceed recommended dosage, should be closely supervised and should be warned to discontinue the drug and report immediately if fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools or other evidence of intestinal hemorrhage occur. Make regular blood counts. Discontinue the drug immediately and institute countermeasures if the white count changes significantly, granulocytes decrease, or immature forms appear. Use greater care in the elderly and in hypertensives.

Adverse Reactions: The most common are nausea, edema and drug rash. Swelling of the ankles or face may be minimized by withholding dietary salt, reduction in dosage or use of diuretics. In elderly patients and in those with hypertension the drug should be discontinued with the appearance of edema. The drug has been associated with peptic ulcer and may reactivate a latent peptic ulcer. The patient should be instructed to take doses immediately before or after meals or with milk to minimize gastric upset. Mild drug rashes frequently subside with reduction of dosage. However, rash accompanied by fever or other systemic reactions usually requires withholding medication. Purpuric rash has also been reported. Agranulocytosis, ex-

In rheumatoid arthritis, Butazolidin alka needs only a week's trial. If it doesn't work in a week, forget it.

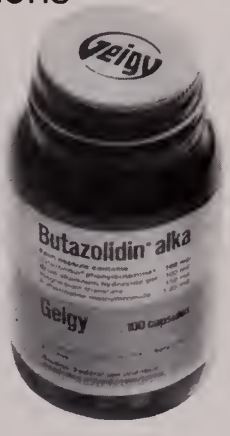
A short trial period may spare patients weeks of discomfort. That's one reason why Butazolidin alka seems a good choice when aspirin fails.

It's not for every patient. Check carefully the Contraindications, Warning, and Precautions shown below.

And adverse reactions may occur. The most common are nausea, edema and rash. Rarely, agranulocytosis has been reported. All adverse reactions are listed below, too.

You'll know quickly if it works.

And most of the time, it will.



foliative dermatitis, Stevens-Johnson syndrome, or a generalized allergic reaction similar to serum sickness may occur and require permanent withdrawal of medication. Stomatitis, salivary gland enlargement, vomiting, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported. While not definitely attributable to the drug, a causal relationship cannot be excluded. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hyperglycemia, hepatitis, jaundice, and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently. Moderate lowering of the red cell count due to hemodilution may occur.

Dosage in Rheumatoid Arthritis: Initial: 3 to 6 capsules or tablets daily in 3 or 4 equal doses. Trial period: 1 week. Maintenance dosage should not exceed 4 capsules or tablets daily; response is often achieved with 1 or 2 capsules or tablets daily.
6509-V(B)R2

For complete details, please see full prescribing information.

Butazolidin® alka

Capsules: phenylbutazone, 100 mg.; dried aluminum hydroxide gel, 100 mg.; magnesium trisilicate, 150 mg.; homatropine methylbromide, 1.25 mg.

Also available: Butazolidin®, phenylbutazone: Tablets of 100 mg.

Geigy Pharmaceuticals
Division of Geigy Chemical Corporation
Ardsley, New York

6U-5412S



The Medical Detective

Go to the Scene

Inspection of the scene of an accidental death may serve not only to reconstruct the mechanism of death, but may also lead to discovery of lingering unsuspected danger. The case presented here will illustrate these points.

A 5-year-old girl disappeared from her home early one morning. Following an extensive two hour search by family and neighbors, the child was found dead, with her head protruding from beneath the outside framing of a barn shed. Inside the shed the child was lying head down with the body wedged between a pile of sand, a turkey incubator and the barn shed wall. The incubator contained turkey poults. The preliminary conclusion was that the child must have fallen from a ledge, while watching the turkeys, becoming wedged between the pile of sand and the barn shed, and therefore being asphyxiated. The medical examiner was not called to the scene of death at this time. Examination of the body in the morgue revealed a child clad only in shorts and a meager halter. There were no significant external markings except for some scratches on the left lateral chest which were roughly parallel. One of these had actually formed a shallow laceration. In addition to these linear parallel markings, there were some markings of a cross-hatched grid work type. At initial examination, it was thought that this grid work pattern and the parallel markings were there largely as the result of dust or dirt markings. It was determined, however, that these markings could not be washed or scratched off and on magnified visualization, the laceration showed possible burning of the wound edges. The pattern of grid markings was so uniform a definite measurement could be made, with the grids measuring ⅞ by 1¾ inches.

Internal examination of the body revealed moderate hyperemia of the major organs, including the lungs, with no significant abnormalities otherwise noted. The lungs did not exhibit the marked congestion usually present in deaths due to asphyxiation. With the negative findings at autopsy, closer scrutiny was given to the markings on the left lateral chest.

Following the nonrewarding autopsy, the medical examiner accompanied the investigator to the scene. At the scene, it was noted that a portion of the incubator for the turkey poults was composed of stiff wire grid with dimensions exactly fitting the grid markings on the child's chest. It was also noted that this portion of the crib was in an area where the child could have become wedged between the incubator and the pile of sand which was moist. Thus the possibility of electrocution was established. Histologic sections of the tissues obtained at the postmortem examination revealed that the markings and the lacerations of the chest wall exhibited coagulative necrosis such as one sees in areas of electrical burn and cautery.

The presence of an electric charge could not be demonstrated in the wire grid which made up

A Continuing series prepared by members of the Florida Society of Pathologists.

the wall of the incubator. A light bulb was burning in the incubator to provide heat, however. In evaluating the incubator for possible presence of an electric charge, one of the investigators inadvertently unplugged the light and replugged it, apparently turning the two prong plug around. It was then noticed that the wire of the incubator was electrically charged. It was still unclear, however, as to how the child could have been electrocuted. Interrogation of all persons who searched for the girl revealed that, when the child had been found, someone had accidentally struck the overhead electrical wiring which caused the plug to drop out of the outlet. The person who did this reinserted the plug without realizing there was any significance attached to it.

In reconstructing the death scene, therefore, it became obvious that the incubator wire cage was electrically charged. The child had apparently tried to climb on top of the mound of sand and apparently fell, wedging her chest between the bottom part of the incubator and the moist sand which was immediately adjacent. The dimensions of the child's body and the distance between the mound of sand and the incubator corresponded perfectly. It seemed probable that the wedging of the chest between the incubator and the mound of sand had been overlooked by the persons who found the child, and that her head being down below the wall of the barn shed probably distracted their attention from this significant fact.

Two interesting points can be made from this medicolegal investigation. First, it demonstrates vividly the importance of on-the-scene investigation by the medical examiner, in order to reconstruct accurately the mechanism of death. As in this case, the on-scene investigation can be invaluable, even though the body may have already been removed.

This case also demonstrates a common home or farm hazard, namely, improperly grounded electrical circuits. It seems, in this case, that there was proper grounding of the electrical circuit when the two prong plug was inserted in one position only. A three prong electrical circuit with a properly connected ground would undoubtedly have prevented the death of this child. The reconstruction of the mechanism of death in this case also brought to light a danger which lingered unsuspected.

L. E. McHenry, M.D.
Melbourne



Recognize this?
Chloresium® Ointment
—it's recognized for effectiveness in healing ulcers, soothing burns, deodorizing wounds. Use this coupon for samples. Rystan

Chloresium Ointment
Brand of water-soluble chlorophyll derivatives

RYSTAN COMPANY (F)
117 Mt. Vernon Ave.
Mt. Vernon, New York
Please send me literature and free samples of CHLORESIUM OINTMENT

Dr. _____

Street _____

City _____ State _____ Zip _____



50 Years Ago in the Journal

December 1917

The December 1917 issue of the Journal was richly blessed with the following varied articles: "War Work of American Medical Women," Eliza M. Mosher, M.D. (home town not listed); "Progressive Ethics," J. H. Coffee, M.D., Fort Meade; "Prevention of Intestinal Diseases, Including Typhoid Fever," M. L. Crum, M.D., Bowling Green; "Relation of the Eye, Ear, Nose and Throat to the Conservation of the Health of School Children," Samuel F. Smith, M.D., Lakeland; "How Much Do We Owe Our Patients?" L. L. Andrews, M.D., Fort Myers; "The Eliminative Treatment of Eclampsia," L. Edward Parmley, M.D., Winter Haven; "Value of Nurse Hired by City or District, 'Community Nurses,'" B. Honeywell, M.D., Lakeland; "The Sanitary Inspector in the Prevention of Diseases," H. O. Snow, M.D., Tampa, and "A New Obstetrical Sheet," G. H. Edwards, M.D., Orlando.

The editorial pages were much concerned with the problem of medical fraud and, of course, with the recruitment and welfare of military physicians for World War I. To savor the problem of medical fraud and quackery of the time and to demonstrate simultaneously the forward thinking of the medical profession in the area of health education, we are reprinting in part Dr. Coffee's philosophical but practical article.

"First, let us be honest enough and brave enough to purge the regular organized medical profession of its liars. There is no more contemptible human jellyfish than the physician who will agree with the prejudices and superstitions of his patients in order to curry favor and because he is too lazy to dispute or argue a question about which he knows that his patient is entirely wrong. He is perfectly willing that his patient believe that it is a case of Bright's disease while he knows that it is merely a cystitis. He is willing to treat and apparently cure a case of Bright's disease while in fact he knows that he is treating a case of catarrhal cystitis. The same principle could actuate that physician to agree that malaria is acquired by drinking impure water, and can be cured by taking calomel. There is also that abominable liar who always arrives just in time to save a life or who has just saved a life by a hair. If they had waited much longer to call him it would have 'run into typhoid fever.' 'Good Lord deliver us.' Let us be honest with the liars in our ranks and reform them or run them out. Let it be known that we will no longer by our silence shield him in his deceptions. When we catch him red-handed, as we often do, let us advise him that we will no longer uphold his quackery, and if this will not bring results, make it an offense against our society and remove him from our ranks. I have heard those whom I know to be good men say that it is necessary to practice some deception, but I am sure they had in mind conditions out of the ordin-

ary and surrounded by circumstances which would make it possible for them to prove that they had acted wisely and perhaps relieved suffering while doing no possible harm whatever. Let us by all means unburden ourselves of the liar and blatherskite.

"My second remedy is sure to succeed if tried. Education is the greatest institution of life. From education must come the beauties and pleasures of the world. It is the only thing that can make the world better. The greatest good can be accomplished by educating people when they are young. Now do you get me? Each school should have among its teachers a physician who should be required to teach—not medicine or drugs except incidently, but health—how to acquire it and how to maintain it. His efforts should be spent in instilling certain fundamental facts into the minds of young women and young men which would make it impossible later in life for a charlatan to impress them except with disgust. Let his instructions have to do with how we are made and why, the location of the vital organs of the body, their functions and the conditions under which these functions can best be carried out and then, above all, the care of these organs and the things that injure them and why. With the youth of the land growing up with a reasonable amount of such information, is it not easy to understand that physicians would have better support in accomplishing the true mission of our calling? The standard of medical education is rising rapidly and it requires more education to enter a medical school today than ever before and it will require more tomorrow. Physicians are better trained when they begin their practice and are able to do more good than ever before, but public opinion knows it not. They do not understand us because we do not let them. We do not take them into our confidence. We stand aside and allow the unworthy to teach them through the daily press of the country and expect them to give us the support without our giving them a reason for it. We know the reason, but do our patients?

"I have never had an ambition to be a reformer. It is a thankless job and besides it calls for lots of work, but it is a shame that we do not use our best efforts to show our people that our ethics stand for their health and happiness. In order that the suggestion herein contained be acted upon, we must make of ours a progressive ethics."



If hypothyroidism leaves your patient feeling like this...

consider

LETTER®

(SODIUM LEVOTHYROXINE, ARMOUR) TABLETS

Synthetic Thyroid Replacement Therapy



Letter® provides all the advantages of the synthetically pure chemical sodium levothyroxine. Dosage is precise and potency is consistently uniform.

and

Letter® is micronized to provide maximum opportunity for full absorption and clinical response.

In addition Letter® is distinctively color coded with an identifying number stamped on each tablet to provide accurate dosage control.

Indications: Hypothyroid conditions. **Contraindications:** Thyrotoxicosis, acute myocardial infarctions unless associated with hypothyroidism. In hypothyroidism with hypoadrenalism coadministration of corticoids with LETTER® is recommended. **Precautions and Side Effects:** Excessive dosage may result in diarrhea, cramps, palpitation, nervousness, rapid pulse, sweating. If symptoms appear, discontinue medication for several days, then reinstitute at a lower level. Since myxedema patients with heart disease may suffer seriously from abrupt increases in dosage, caution should be exercised in adjusting dosage. **Dosage:** Generally, the initial adult dosage is 0.1 mg. daily. This may be increased in small increments every one to three weeks until proper metabolic balance is achieved. **Available:** Bottles of 100 tablets, in six potencies: 0.025 mg. (violet), 0.05 mg. (peach), 0.1 mg. (pink), 0.2 mg. (green), 0.3 mg. (yellow), and 0.5 mg. (white).

ARMOUR PHARMACEUTICAL COMPANY • CHICAGO, ILLINOIS



"Man's best friend" in wintertime diarrheas

In winter "flu" and viral gastroenteritis, Donnagel (4 oz. size!) can bring aid and comfort to sufferers from both diarrhea and its discomforts because it contains kaolin and pectin *plus* belladonna alkaloids (as in Donnatal®). Donnagel treats the whole diarrhea problem. Available on your prescription or recommendation.

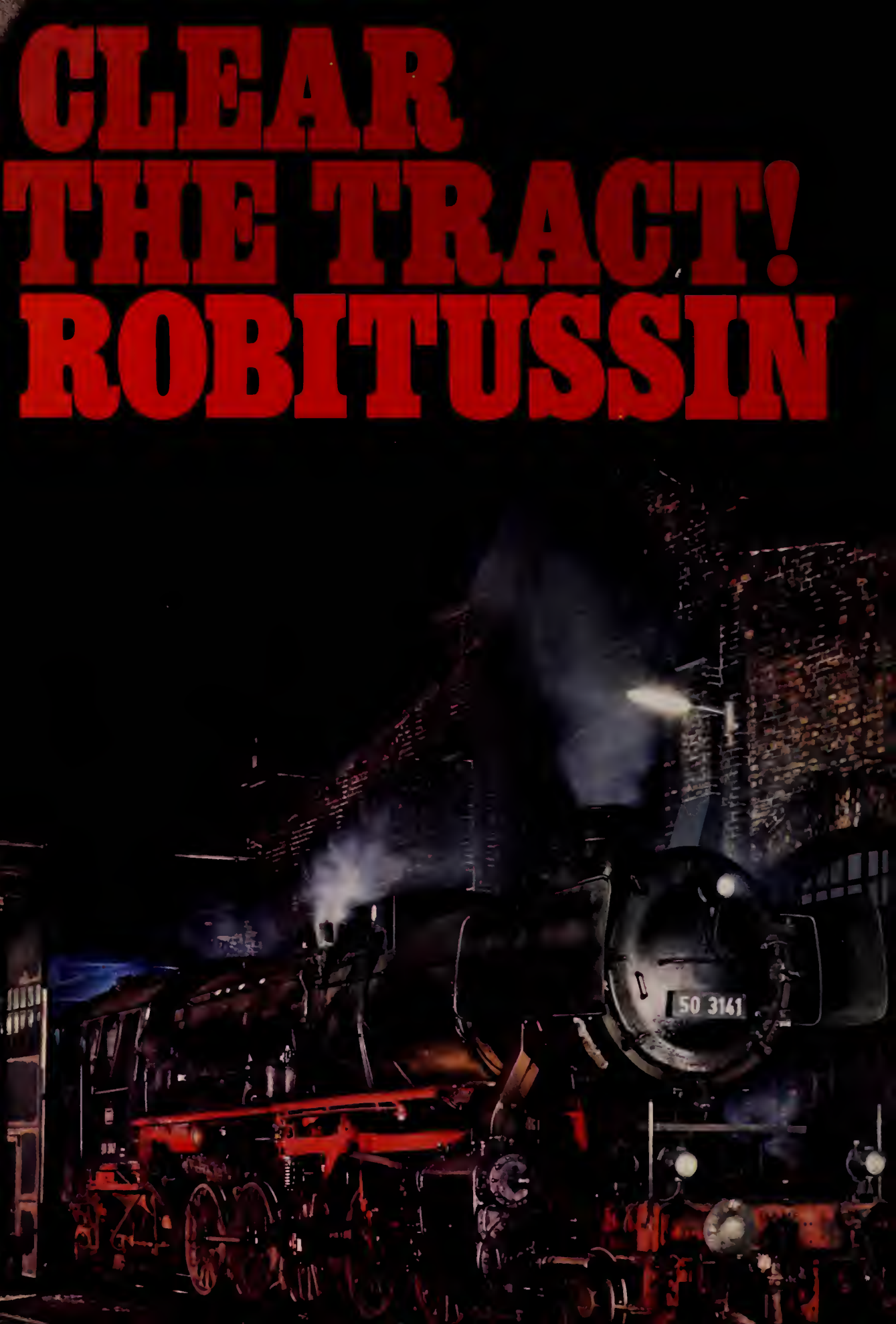
For acute, non-specific diarrheas **Donnagel® -PG** (Donnagel with paregoric equivalent). Donnagel formula plus powdered opium, USP, 24.0 mg. (equivalent to paregoric 6 ml.) (warning: may be habit forming). Alcohol, 5%.

All the antidiarrheal benefits of paregoric without the unpleasant taste. Real banana flavor makes it acceptable, even to children. See product literature before prescribing.

A. H. Robins Company
Richmond, Va. 23220

A·H·ROBINS

CLEAR THE TRACT! ROBITUSSIN



THERE'S A FORMULATION FOR EVERY COUGHING NEED

All the Robitussins contain glyceryl guaiacolate, the outstanding expectorant agent that greatly increases the output of lower respiratory tract fluid. Increased RTF volume exerts a demulcent effect on the tracheo-bronchial mucosa, promotes ciliary action, and makes thick, inspissated mucus less viscid and easier to raise.

For coughs of colds and "flu"
ROBITUSSIN®
Each 5 cc. contains:
Glyceryl guaiacolate 100 mg.
Alcohol, 3.5%

For unproductive allergic coughs
ROBITUSSIN® A-C
Each 5 cc. contains:
Glyceryl guaiacolate 100 mg.
Pheniramine maleate 7.5 mg.
Codeine phosphate 10.0 mg.
(warning: may be habit forming)
Alcohol, 3.5%

Non-narcotic for 6-8 hour cough control
ROBITUSSIN®-DM
Each 5 cc. contains:
Glyceryl guaiacolate 100 mg.
Dextromethorphan hydrobromide . 15.0 mg.
Alcohol, 1.4%

New! Clears sinuses and nasal stuffiness as it relieves cough
ROBITUSSIN®-PE
Each 5 cc. contains:
Glyceryl guaiacolate 100 mg.
Phenylephrine hydrochloride . . . 10.0 mg.
Alcohol, 1.4%

	ROBITUSSIN	ROBITUSSIN A-C	ROBITUSSIN-DM	ROBITUSSIN-PE
EXPECTORANT	●	●	●	●
DEMULCENT	●	●	●	●
COUGH SUPPRESSANT		●	●	
ANTIHISTAMINE		●		
LONG-ACTING (6-8 HOURS)			●	
NASAL, SINUS DECONGESTANT				●

PHOTO BY VICTOR HAND

A. H. Robins Company, Richmond, Va. 23220

A·H·ROBINS



Government News

Head Start Medical Consultation Program

A new partnership between Project Head Start and the pediatricians of America was announced recently by the Office of Economic Opportunity and the American Academy of Pediatrics.

Sargent Shriver, director of OEO, and William S. Anderson, M.D., president of the AAP, in a joint statement, said that the Academy will organize and direct the Medical Consultation Program of Head Start child development programs in nearly 2,000 communities throughout the United States.

The Academy has chosen Robert S. Mendelsohn, M.D., Chicago pediatrician and former Project Head Start medical director, Cook County OEO, to direct the program. Shriver stressed that this contract represents a new type of relationship between an agency of the federal government and a voluntary professional organization. In effect, the AAP has accepted a major responsibility for ensuring that the health services provided to Head Start children adequately meet the health needs of these children, their families and the community in which they live.

Dr. Anderson said that initially the AAP will select about 300 physician consultants from its membership and from other leaders in the field of child health to evaluate the medical aspects of the Head Start program at the state and local level.

Each medical consultant selected will work with the medical director and other health professionals in Head Start projects and will review the medical aspects of Head Start applications submitted by a community; meet with local planning committees to map out Head Start medical programs; maintain contact with program medical directors; follow up and evaluate programs, and maintain liaison with OEO regional and national offices.

Drug Practices – Prehistoric to Present

Native drug practices, from prehistoric tribal rites to the contemporary psychedelic scene, are given historical perspective in a new book, Ethnopharmacologic Search for Psychoactive Drugs, issued recently by the National Institute of Mental Health, U.S. Public Health Service.

The 450-page publication contains the proceedings of a symposium held earlier this year in San Francisco under the sponsorship of the psychopharmacology research branch of the NIMH. Speakers from more than 10 nations met for the first time to exchange information and stimulate research in a field that professionals feel has been relatively neglected.

Although the use of plants or their extracts for medicinal and religious purposes is practically as old as the human race, this symposium was the first attempt to bring together international ex-

perts and to consolidate all presently available information. Participants were invited from a wide variety of scientific disciplines to discuss current progress and problems in the area of historical drug research.

One of the problems of research in this field is the difficulty encountered in tracing native drug practices back through history. As the science of drug chemistry has become more complex, the primary sources of these drugs have too often been lost in obscurity. At the same time, the intrusions of civilization have progressively destroyed many of the original botanical sources. Thus, according to Dr. Daniel H. Efron of the psychopharmacology research branch, who edited the book, "time is running out if we want to save this information, and perhaps use for medicinal purposes some of the unknown compounds contained in some of these plants."

Copies of the book, Public Health Service Publication No. 1645, are available at $4, Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402.

YOUR Patronage Has Made Our Growth Possible

Medical Supply Company of Jacksonville



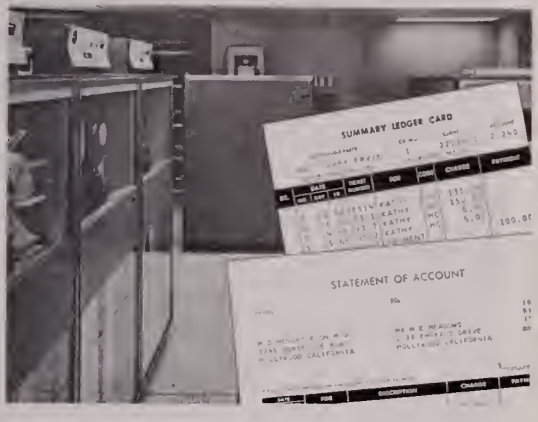
Home Office

JACKSONVILLE
4539 Beach Blvd.
Telephone FL 9-2191

ORLANDO
1511 Sligh Blvd.
Telephone GA 5-3537

ASSOCIATED MANAGEMENT INC.
FIRST FEDERAL BUILDING
8340 N.E. 2ND AVENUE
MIAMI, FLORIDA 33138

Accounts receivable management system designed specifically for doctors



This system offers doctors the advantage of computer techniques for accounts receivable management with no investment in equipment. All that's required from the doctor is a daily report voucher on each patient. From this, AMS furnishes a whole series of regular reports and analyses plus the preparation of each patient's monthly statement. The cost is usually far less than doing your own bookkeeping.

We are part of a National Concern serving Doctors for over 6 years.

☐ Please send me your Accounts Receivable Management Brochure.

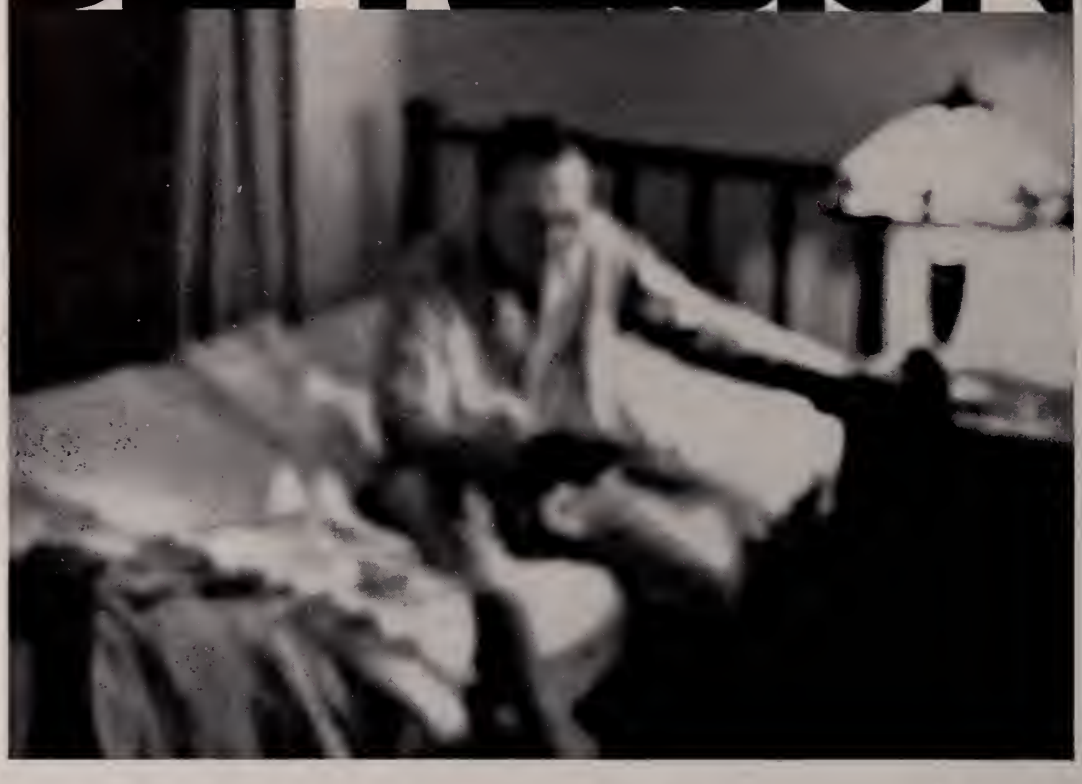
☐ Please have one of your consultants call me for an appointment.

Name

Address

City Phone

DEPRESSION



NORPRAMIN®
(desipramine hydrochloride)

ANTIDEPRESSANT FOR RAPID IMPROVEMENT

At the recommended dosage level —initially, 150 mg. per day— gratifying remission of the signs and symptoms of depression typically begins in 2-5 days. Its specificity for depression, rapidity of action and usually mild side effects are significant reasons for prescribing NORPRAMIN (desipramine hydrochloride) in depression of any type . . . any degree of severity.

A few patients, sensitive to central nervous system stimulants may become restless as depression is lifted—in such cases dosage may be reduced or a tranquilizer added.

IN BRIEF:

INDICATIONS: In depression of any kind —neurotic and psychotic depressive reactions; manic-depressive or involutional psychotic reactions.

CONTRAINDICATIONS: Glaucoma, urethral or ureteral spasm, recent myocardial infarction, severe coronary heart disease, epilepsy. Should not be given within two weeks of treatment with a monoamine oxidase inhibitor.

RELATIVE CONTRAINDICATIONS: (1) Patients with a history of paroxysmal tachycardia. (2) Patients receiving concomitant therapy with thyroid, anticholinergics or sympathomimetics may experience potentiation of effects of these drugs. (3) Safety in pregnancy has not been established.

PRECAUTIONS: (1) Outpatient use of desipramine hydrochloride should not be substituted for hospitalization when risk of suicide or homicide is considered grave. (2) If serious adverse effects occur, reduce dosage or alter treatment. (3) In patients with manic-depressive illness a hypomanic state may be induced. (4) Discontinue drug as soon as possible prior to elective surgery.

ADVERSE EFFECTS: Side effects, usually mild, may include: dry mouth, constipation, dizziness, palpitation, delayed urination, "bad taste," sensory illusion, tinnitus, anxiety, agitation and stimulation, insomnia, sweating, drowsiness, headache, orthostatic hypotension, flushing, nausea, cramps, weakness, blurred vision and mydriasis, rash, tremor, allergy, agranulocytosis, altered liver function, ataxia, and extrapyramidal signs.

DOSAGE: Optimal results are obtained at a dosage of 50 mg., t.i.d. (150 mg./day). **SUPPLIED:** NORPRAMIN (desipramine hydrochloride) tablets of 25 mg.; bottles of 50, 500 and 1000; and tablets of 50 mg., in bottles of 30, 250 and 1000.

LAKESIDE

LAKESIDE LABORATORIES, INC., Milwaukee, Wisconsin 53201

NEWS

The Late Dr. Shaler A. Richardson

New UF Outpatient Eye Clinic Named for FMA Editor Emeritus

The new outpatient eye clinic of the University of Florida's Shands Teaching Hospital Clinic was dedicated and officially named for Dr. Shaler Arnold Richardson, late Jacksonville ophthalmologist, in a recent ceremony in Gainesville.

Dr. Richardson, who died in May 1964, was called the father of ophthalmology in Florida for his pioneering work in the field and for the idea of the clinic.

According to Dr. Herbert Kaufman, professor and chairman of the Department of Ophthalmology at the University's College of Medicine, Dr. Richardson had a vital role in the preliminary planning for the clinic and had previously helped to establish the Department of Ophthalmology.

Dr. Richardson served as president of the Florida Medical Association in 1946, was the only Florida physician holding membership in the American Ophthalmological Society and helped found the Florida Council for the Blind and the indigent eye clinic at Duval Medical Center in Jacksonville.

He served for 30 years as editor of the Journal of the Florida Medical Association.

The program included brief dedicatory speeches by Dr. Samuel P. Martin, provost of the J. Hillis Miller Health Center; Dr. Richard P. Schmidt, associate dean of the College of Medicine, and Rev. George H. Murphy of Grace Chapel Parish (Episcopal) in Jacksonville, a personal friend of the Richardson family and a coworker in establishing the clinic.

Before the dedication ceremony a postgraduate ophthalmology seminar was held, with Dr. Edward W. D. Norton, head of the Department of Ophthalmology at the University of Miami School of Medicine, serving as visiting professor.

A plaque, portrait and book collection in the new clinic will honor Dr. Richardson's memory. The books, old and valuable items from his personal library, will be kept in the clinic's library conference room.

The clinic, which cost more than $100,000, was financed completely by private gifts from the family and friends of Dr. Richardson, from many of the practicing physicians in Florida and other interested individuals.

Members Overseas

Dr. Joseph C. Doane, West Palm Beach urologist and FMA member, recently flew to Cartagena, Colombia, South America, to join the medical teaching and treatment mission on board the S.S. Hope.

Dr. Doane is to serve on the floating medical center for two months.

Dr. Henry M. Stern, Lakeland surgeon and FMA member, recently returned from Ecuador where he spent a month under an American Doctor (AMDOC) program.

During the past two years Dr. Stern has gone to Haiti under the same program.

Dr. Jose L. Zubero, Jacksonville ophthalmologist and FMA member, was among a group of U.S. physicians recently arriving in Saigon, South Vietnam, the latest contingent of American MD's to begin two months of service under the American Medical Association Volunteer Physicians for Vietnam program.

Federal Court Decision Opens Door to MD Corporate Tax Status

Corporate tax status of physicians was, in effect, upheld in a recent Colorado federal trial court ruling.

The Treasury Department's so-called Kintner regulations, restricting professional groups in obtaining tax advantages of corporations, have been declared invalid.

The ruling, permitting an association of lawyers to be taxed as a corporation rather than as a partnership, is the first court decision on the validity of the Kintner regulations.

The decision, Empey v. U.S. (U.S. Dist. Ct., Colo.; Aug. 31, 1967), is applicable also to physicians.

The Kintner regulations arose from an unsuccessful attempt of the Treasury Department (U.S. v. Kintner, 1954) to tax certain unincorporated associations of physicians as partnerships rather than as corporations.

The Internal Revenue Service announced it would not follow the Kintner decision and in 1960 the Treasury Department adopted regulations designed to offset the effect of the Kintner case and to make it as difficult as possible for unincorporated organizations to be taxable as corporations.

As a result, self-employed professional persons turned to state legislatures. Some 34 states adopted statutes designed to permit professional persons to obtain "association" or "corporation" status for federal tax purposes.

The Treasury Department, in response to the outpouring of state legislation, countered with the 1965 Treasury Regulations (Kintner regulations) which provided, in essence, that an organization of professional persons, incorporated or unincorporated, cannot be taxed as a corporation unless ". . . the corporate characteristics are such that the organization more nearly resembles a corporation than a partnership or a trust."

The Colorado court, after reviewing statutory definitions of partnerships and corporations as stated in the Internal Revenue Code and upon reviewing court decisions regarding the IRC, concluded the Treasury regulations were ". . . inconsistent with the statute and the judicial construction thereof and that the regulations constitute the exercise of a non-delegable legislative function and are invalid and unenforceable."

Associate Hospital Dean Appointed at UM

Dr. Frank Moya, professor and chairman of the Department of Anesthesiology at the University of Miami School of Medicine, has been appointed associate dean for hospital affairs.

Announcing the appointment, Dr. W. Dean Warren, dean of the medical school, described the post as "a key position in the university's plans for the development of an outstanding medical center."

In his new capacity, Dr. Moya will serve as director of medical school activities in Jackson Memorial Hospital, the National Children's Cardiac Hospital and the Veterans Administration Hospital.

The appointment is effective immediately and is in addition to Dr. Moya's departmental chairmanship.

Dr. Moya is widely known in the profession for his research work, particularly in the field of obstetric anesthesia and in newborn physiology. He is the author of 67 research papers and is frequently called on as a guest lecturer at national and international medical gatherings.

He is chairman of the American Society of Anesthesiologists' Committee on Research, and serves on the Anesthesiology Training Committee as special consultant to the National Institute of General Medical Science of the National Institutes of Health.

A New Yorker, Dr. Moya obtained his BA at New York University, and his MD at State University College of Medicine, New York, in 1953. Following active duty in the Navy's medical corps, he joined the faculty of Columbia University College of Physicians and Surgeons in 1958. He came to the UM medical school from Columbia in 1962 to head the Department of Anesthesiology at the age of 33, the youngest fulltime chairman in the country.

Before prescribing, see complete prescribing information in SK&F literature or *PDR*. A brief precautionary statement follows.
Contraindications: Glaucoma, prostatic hypertrophy, stenosing peptic ulcer, pyloroduodenal obstruction, or bladder neck obstruction.
Precautions: Use cautiously in the presence of hypertension, hyperthyroidism, coronary artery disease; warn vehicle or machine operators of possible drowsiness.
Usage in Pregnancy: Use cautiously, especially in the first trimester. *Note:* The iodine in isopropamide iodide may alter PBI test results and will suppress I^{131} uptake; discontinue 'Ornade' one week before these tests.
Adverse Reactions: Drowsiness; excessive dryness of nose, throat or mouth; nervousness; insomnia. Other known possible side effects of the individual ingredients: nausea, vomiting, diarrhea, rash, dizziness, fatigue, tightness of chest, abdominal pain, irritability, tachycardia, headache, difficulty in urination. Thrombocytopenia, leukopenia and convulsions have been reported but no causal relationship has been established.



a stuffy nose is no laughing matter

Ornade® Trademark

Each capsule contains 8 mg. of Teldrin® (brand of chlorpheniramine maleate), 50 mg. of phenylpropanolamine hydrochloride, and 2.5 mg. of isopropamide, as the iodide.

Spansule® Capsules

brand of sustained release capsules

each one can give him all-day or all-night relief

SK&F Smith Kline & French Laboratories

DIURESIS



MERCUHYDRIN®
(meralluride injection)

LAKESIDE

Twenty years ago the publication of "A System for the Routine Treatment of the Failing Heart"[1] established a schedule of diuretic therapy as a primary factor in the treatment of acute congestive failure. With emphasis upon daily injections of Mercuhydrin (meralluride injection) until dry weight was obtained, Gold, et al. achieved a 40% increase in improvement, in ⅓ the time, over other methods then current. Today, most medical texts continue to recommend parenteral mercurials in acute congestive failure when prompt diuresis is indicated.

Recently Modell[2] has stated: "The mercurial diuretics are the injectable diuretics of choice since they are the most potent as well as the most dependable. Their toxicity is not an important consideration either by comparison with other potent diuretics or in relation to the seriousness of the conditions in which they provide such excellent relief."

IN BRIEF

Mercuhydrin is indicated in edema of cardiac or hepatic origin and in the nephrotic syndrome; it is contraindicated in acute nephritis and in anuric or oliguric states. *The usual adult dose is one to two cc. daily or every other day until "dry weight" is obtained.* Sensitivity is rare but small initial doses are advised to minimize potential reactions; vertigo, fever, and rash have occurred. Overdosage may produce electrolyte depletion, muscle cramps, and G. I. reactions. Supplied: 1 cc. and 2 cc. ampuls in boxes of 12, 25 and 100; 10 cc. rubber capped, multiple-dose vials (intramuscular or subcutaneous use only) in boxes of 6 and 100.

1. Gold, Harry, *et al.: A System for the Routine Treatment of the Failing Heart,* The American Journal of Medicine, Vol. III, No. 6:665-692 (Dec.) 1956.

2. Modell, Walter: *Drugs of Choice 1966-1967,* p. 97, 1966.

LAKESIDE LABORATORIES, INC., Milwaukee, Wisconsin 53201



after surgery

B and C vitamins are therapy: Therapeutic amounts of B and C in stress formula vitamins often are vital during periods of physiologic stress. STRESSCAPS capsules, designed to meet increased metabolic demands, aid in achieving a more comfortable convalescence, a more rapid recovery. After surgery, as in many stress conditions, STRESSCAPS vitamins are therapy.



Stresscaps®

Stress Formula Vitamins Lederle

FOR PROFESSIONAL RECOMMENDATION ONLY

Each capsule contains:

Vitamin B_1 (Thiamine Mononitrate)	10 mg
Vitamin B_2 (Riboflavin)	10 mg
Vitamin B_6 (Pyridoxine HCl)	2 mg
Vitamin B_{12} Crystalline	4 mcgm
Vitamin C (Ascorbic Acid)	300 mg
Niacinamide	100 mg
Calcium Pantothenate	20 mg

Recommended intake: Adults, 1 capsule daily, for the treatment of vitamin deficiencies. Supplied in decorative "reminder" jars of 30 and 100; bottles of 500.

LEDERLE LABORATORIES, A Division of American Cyanamid Company, Pearl River, New York

Lederle

627-6—3613

When the agitated geriatric disrupts the home...

His teen-age granddaughter won't invite friends home because of his outbursts.



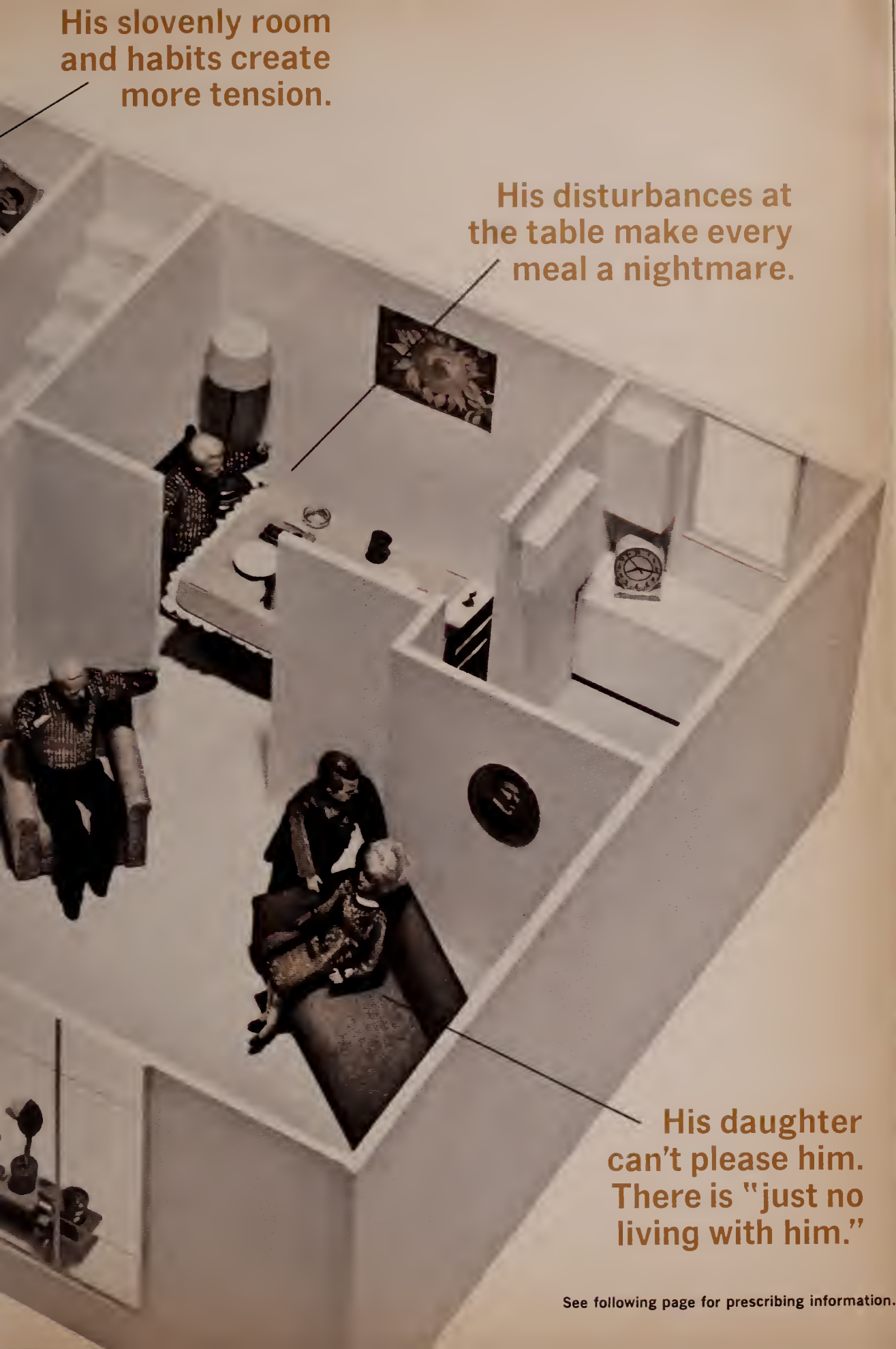
for moderate to severe anxiety

Mellaril®
(thioridazine)
25 mg. t.i.d.

SANDOZ

His slovenly room and habits create more tension.

His disturbances at the table make every meal a nightmare.



His daughter can't please him. There is "just no living with him."

See following page for prescribing information.

When the agitated geriatric disrupts the home...

Anxiety that *seriously interferes* with the individual's performance at work, at home, or in the community may be regarded as *moderate to severe* in degree.

Mellaril often recommends itself to the treatment of moderate to severe anxiety because it

- helps control the most frequent symptoms: marked tension, agitation, apprehension, restlessness, hypermotility
- often alleviates anxiety-induced somatic complaints
- frequently helps strengthen emotional resources
- helps the patient maintain realistic contact with environment, closer harmony with family

Thus, when you consider the anxiety moderate to severe... consider Mellaril.

Contraindications: Severely depressed or comatose states from any cause, and in association with or following MAO inhibitors; severe hypertensive or hypotensive heart disease.

Precautions: Hypersensitivity reactions (e.g., leukopenia, agranulocytosis) and convulsive seizures are infrequent. Pigmentary retinopathy has been observed where doses in excess of those recommended were used for long periods of time. May potentiate central nervous system depressants, atropine, and phosphorus insecticides. Where complete mental alertness is required, administer the drug cautiously and increase dosage gradually. In addition, orthostatic hypotension (especially in female patients) has been observed. Epinephrine should be avoided in treatment of drug-induced hypotension.

Side Effects: Pseudoparkinsonism and other extrapyramidal disorders are infrequent; drowsiness, especially in high doses early in treatment, may occur; nocturnal confusion, dryness of the mouth, nasal stuffiness, headache, peripheral edema, lactation, galactorrhea, and inhibition of ejaculation are noted on occasion; photosensitivity and other allergic skin reactions may occur but are extremely rare.

Before prescribing, see package insert for full product information.

for moderate to severe anxiety

Mellaril®
(thioridazine)
25 mg. t.i.d.

SANDOZ

mudrane®

for

- EMPHYSEMA
- ASTHMA
- CHRONIC BRONCHITIS
- BRONCHIECTASIS

The fast-disintegrating uncoated tablet gives relief in 15 minutes

Each tablet contains:

Potassium Iodide	195 mg.
Aminophylline	130 mg.
Phenobarbital, Caution: May be habit forming...	21 mg.
Ephedrine HCl	16 mg.

FEDERAL LAW PROHIBITS
DISPENSING WITHOUT PRESCRIPTION

Precautions: Usual for aminophylline-ephedrine-phenobarbital. Iodides may cause nausea, long use may cause goiter. Discontinue if symptoms of iodism develop.

Iodide contraindications: tuberculosis, pregnancy.

DOSAGE

One tablet, with full glass of water, 3 or 4 times daily.

Dispensed in bottles of 100 and 1000 tablets.

MUDRANE GG—Formula, dosage and package identical to Mudrane—*except*—100 mg. glyceryl guaiacolate replaces the potassium iodide. The value of Mudrane cannot be enjoyed by a small group in which K.I. is contraindicated. Mudrane GG is prepared for this group.

MUDRANE GG ELIXIR—Four 5 cc teaspoonfuls is equivalent to one Mudrane GG tablet. Dosage adjusted to age and weight of child. Mudrane GG Elixir is for pediatric patients and those who think they cannot swallow tablets. Dispensed in pint and half gallon bottles.

WM. P. POYTHRESS & CO., INC.
RICHMOND, VIRGINIA 23217
Manufacturers of ethical pharmaceuticals since 1856



Public Health Topics

Problems with Parathion Poisoning

To the world, the recent tragic events in Tijuana, Mexico, where over 300 persons were accidentally poisoned by parathion, came as a somber reminder of the lethality and ready availability of this insecticide. To Floridians, still more recently, the news of the deaths of seven children was a further reminder of the proximity of risk within our own community.

Poisoning by parathion presents the attending physician with one of the most urgent medical emergencies he can be called upon to attend. Time is always at a premium and not infrequently the successful outcome of this emergency is dependent upon the rapidity with which diagnosis and treatment are made. For four years, the Florida State Board of Health in conjunction with the University of Miami School of Medicine has been exploring the total health effects of pesticides through the Community Pesticides Studies Program. The acute poisoning incident is one area of special concern and in Dade County intensive epidemiological, clinical and toxicological information has been collected on every poisoning due to pesticides occurring in this period. More than 100 cases have been studied and parathion has been the chemical found to be responsible for over one-half of these intoxications. The special experiences encountered in cases of poisoning with this insecticide are hereinafter discussed under the headings of epidemiology, clinical and diagnostic aspects and methods of prevention.

Epidemiological Aspects

In this intensive study of pesticide poisonings, of which 28 were fatal, the organophosphate group of insecticides has been found to be the most frequent and most lethal. With the assistance of William Cohen and Alan Miller, senior medical students at the University of Miami School of Medicine, a survey of 89 cases in four major hospitals in Dade County during the period January 1963 to August 1965 was especially studied. Forty-six poisonings occurred in adults and 43 in children. The adult poisonings included 32 who became ill through accidents in the home or at work and 14 who died as a result of suicide or homicide. Of the 43 children investigated, 40 intoxications involved Negro infants whose average age was 2½ years; the male-female ratio was 3:1. Not always were these poisonings found to be due to the leaving of pesticides within reach of the small child. On four occasions information was received of the prior visit of an illicit peddler selling parathion as "roach powder" and dispensing it in an unlabeled container. So striking has been the special vulnerability of the Negro child that Davis stated, "For all practical purposes, in our community of Dade County, a small toddler who begins to cry, staggers, collapses and has seizures on the way to, or on arrival at, the hospital, should be considered to be a case of parathion poisoning, until proved otherwise."[1]

Under these circumstances, therefore, it is not surprising that several local municipalities in south Florida have enacted local ordinances designed to prohibit the over-the-counter sale of the more toxic insecticides to the untrained or the nonprofessional user.

Clinical and Diagnostic Aspects

In addition to convulsions, patients have presented with pneumonic onset, pulmonary exudation fever and a polymorpholeukocytosis. On other occasions, the major presenting symptoms and signs have included abdominal cramps, nausea, vomiting and a 2 to 4+ glycosuria with concomitant glycosemia. Since 30% of cases have demonstrated dilated rather than miotic pupils, one can easily understand how an initial misdiagnosis may be made on account of the similarity of the presenting symptoms with other more common diseases. In spite of these variations in the mode of onset, it is not long before the general picture of nicotinic and muscarinic stimulation becomes very apparent. The general principles of treatment have not changed very much over the last four years and the literature contains many descriptions of the ideal therapeutic regimen. Hayes,[2,3] Zavon,[4] West et al[5] and Deichmann[6] emphasized the need for vigorous decontamination, especially the hair, and supportive therapy on the one hand, and the combined use of atropine and 2-PAM (2-pyridine aldoxime methylchloride) on the other.

In so far as decontamination is concerned, the potential of urinary paranitrophenol (PNP) monitoring should be emphasized. This metabolite is an excellent indicator both of the severity of the intoxication and also the continued presence and absorption of parathion. To be meaningful, all urinary values should be corrected to an osmolality of 1000 mOSM/kg and recently Mallinckrodt et al[7] have described a rapid identification of paranitrophenol in urine. Atropine dosage titrated against pupillary response and in doses of 2 to 4 mg. every 15 minutes intramuscularly or intravenously should be continued until recovery is obvious and if PNP monitoring is possible until no further metabolite excretion is detected. In a case of suicide, we have had to maintain atropine therapy for as long as 10 days.[8]

The diagnosis of poisoning is a clinical one and treatment should not be postponed until laboratory confirmation is available. It is equally important, however, to obtain a pre-PAM blood for cholinesterase measurement and, likewise, the first gastric washing should be saved for PNP analysis, or if gas chromatograph services are available, by analysis and confirmation of parathion itself. Recently, Freal et al[9] have demonstrated parathion in whole blood by gas chromatography with electron capture detector.

Usually, there is a rapid restoration of erythrocyte and plasma cholinesterase values following 2-PAM therapy. The magnitude and duration of this restoration response is to some extent dependent upon the nature and severity of the poisoning. This makes the interpretation of cholinesterase values difficult at times if the blood has been collected after 2-PAM therapy and, likewise, since paranitrophenol or parathion is indicated in the first gastric washings only. Mann, in an excellent review of the diagnosis of parathion poisoning, has summarized the interpretation of these laboratory procedures.[10]

In conclusion, prevention of recurrences of the problem is one of legislation, information and education. Legislation is required to remove this chemical, in the urban setting, from the hands of persons untrained and unskilled. In agricultural areas, where the worth of the chemical appears to outweigh the risks, education and training are required, especially to emphasize the most important lesson—don't introduce this chemical into the home.

References

1. Davis, J. H.; Davies, J. E., and Fisk, A. J.: Occurrence, Diagnosis and Treatment of Organophosphate Pesticide Poisoning in Man, Bull. N. Y. Acad. Sci. 1967. (In press).
2. Hayes, W. J., Jr.: Clinical Handbook on Economic Poisons. U. S. Government Printing Office, Washington. D. C., 1963.
3. Hayes, W. J., Jr.: Parathion Poisoning and Its Treatment, J.A.M.A. 192:49-50 (Apr. 5) 1965.
4. Zavon, M. R.: Diagnosis and Treatment of Pesticide Poisoning, Arch. Environ. Health (Chicago) 9:615-620 (Nov.) 1964.
5. West, I.: Safe Handling of Pesticides, APHA Subcommittee Manual, 1966.
6. Deichmann, W. B.: Safe Handling and Use of Organic Phosphate Pesticides, Indust. Med. Surg. 36:267-274 (Apr.) 1967.
7. Mallinckrodt, G. M.: Rapid Identification of Urinary p-Nitrophenol in Parathion Poisoning, Research in progress, No. 4, 1967.
8. Wyckoff, D. W.; Davies, J. E.; Barquet A, and Davis J. H.: Diagnostic and Therapeutic Problems of Parathion Poisonings, Ann. Int. Med. (in press).
9. Freal, J. J.; Barquet, A., and Nachman, G. A.: Identification of Newer Pesticides in Blood from Cases of Human Poisoning and Occupational Exposure (to be published).
10. Mann, J. B.: Diagnostic Aids in Organophosphate Poisoning, Ann. Int. Med. 67:905 (Oct.) 1967.

John E. Davies, M.D.
Principal Investigator
Community Studies on Pesticides
Dade County
Florida State Board of Health
Miami



Letters

Dear Editor:

I believe it a responsibility to draw your attention to a misleading and inaccurately labeled photograph(Fig. 5) in "Jackson Memorial Hospital: A Half Century of Community Service," by William M. Straight, M.D., in the August Journal, Vol. 54, No. 8, p. 785, 1967.

This figure is referred to in the text (pp. 793, 795) in only two single lines which do not indicate the outlines of the Medical Center; neither are they indicated on the photograph. Yet the photograph, entitled "The University of Miami—James M. Jackson Memorial Medical Center—1965," also includes (1) the maintenance farm for city vehicles; (2) all municipal buildings in the 14th Street-12th Avenue complex; (3) Cedars of Lebanon Hospital; (4) Jackson Nursing Home; (5) the Orange Bowl, and (6) blocks and blocks of unidentified housing or public buildings. In the future, the Orange Bowl may be required for the conduct of medical grand rounds, but until then it should be cropped from photographs of the medical center or accurately labeled in them.

I have enclosed the photograph with a line drawn around the medical center, including (I think charitably) Jackson Drugs, Pappas' Grill, the new Professional Building (Site No. 4) and the new VA Hospital (Site No. 5). Neither of the latter existed when Dr. Straight's previous (and virtually unreworded) article on Jackson Memorial Hospital appeared in the Journal. The area included within the pen and ink line, which I submit Dr. Straight should have drawn, is half or less of the total photo.

There is some humor in the unidentified figure, padding, as it does, the true outlines of the medical center. It is probably even a trivial matter to you who *know* the Orange Bowl, and the jail, and so forth. What of the reader who doesn't know the local geography? Is the Journal to be only the self-serving organ of the local inbred who recognize the Orange Bowl? I believe not. I believe that the official Journal of a state medical association, especially in its touted "Historical Number," should seek impeccable accuracy in its presentations.

If a "picture is worth a thousand words," Figure 5 tells me it might be necessary to doubt other photographs, other captions, appearing in the Journal. Dr. Straight, an instructor in the History of Medicine, has had ample opportunity, through access to live and reading audiences, to demonstrate fervor and enthusiasm for his subject. The medical center will be as big as Figure 5 fast enough, soon enough (although it may never reach the Orange Bowl). Until then, slips of the mind, pen and camera, such as Figure 5, should not be tolerated, either by you, me or Dr. Straight.

ROGER M. MORRELL, M.D.
MIAMI



Meetings

Approved by FMA
Committee on Postgraduate Education

December

2 RX for the Future — Horizons of Medicine, 1967. Gulf Life Insurance Company, Gulf Life Tower, Jacksonville.

14-16 Modern Concepts in Surgery and Management of the Lower Extremity Amputee, Americana Hotel, Miami Beach.

January

4- 7 Recent Advances in Local Anesthetics and Regional Anesthesia, Eden Roc Hotel, Miami Beach.

11-13 Seminar in Surgery Art and Science in the Therapy of Difficult Problems in Surgery, Eden Roc Hotel, Miami Beach.

15-19 Neurology for the Internist, Eden Roc Hotel, Miami Beach.

18-20 Pediatric Seminar, J. Hillis Miller Health Center, Gainesville.

25-26 Obstetrics & Gynecology Seminar, J. Hillis Miller Health Center, Gainesville.

26-28 Current Results of Treatment of Gynecological Cancer, Eden Roc Hotel, Miami Beach.

28-Feb. 1—Infectious Disease in Children, Deauville Hotel, Miami Beach.

31-Feb. 2 Rational Therapy and Control of Tuberculosis, Robert Meyer Hotel, Jacksonville.

February

4- 9 The Difficult Medical Patient, Fontainebleau Hotel, Miami Beach.

March

2 Current Medical Concepts, Watson Clinic, Lakeland.

15-20 Second International Congress of Lymphology, Fontainebleau Hotel, Miami Beach.

18-22 Corneal and Ophthalmic Plastic Surgery, Hollywood Beach Hotel, Hollywood.

26-28 Infections Control in Hospitals and Institutions—Administrative, Florida State Board of Health Building, Jacksonville.



Take five...

LABSTIX® provides 5 important urinary findings*—on a single reagent strip! That's *more* information than you can get from any other single reagent strip. You know the results in just 30 seconds—while the patient is still in your office—and readings are reliable and reproducible. LABSTIX is easy to handle, too. Never goes limp, even when wet, because it's made with clear, firm plastic. And results with LABSTIX are easy to read—color contrast between the test areas and the transparent plastic is clearly defined. An unexpected "positive" from testing with LABSTIX may help in detecting hidden pathology before marked symptoms are manifest.

*Blood; ketones; glucose; protein, and pH.

AMES COMPANY
Division Miles Laboratories, Inc.
Elkhart, Indiana 46514

Ames

Note: *AMERICAN HOSPITAL FORMULARY SERVICE CATEGORY NUMBER 36:88*

40167



...Plus one

You can extend your testing scope by including ICTOTEST® Reagent Tablets, the 30-second determination for bilirubinuria—which can be an early sign of obstruction of the common bile duct, infectious hepatitis, or other liver disease. This test is also useful for detecting liver damage from carbon tetrachloride and other halogenated hydrocarbons used as industrial and household solvents. Positive findings with the urine-testing team of LABSTIX and ICTOTEST can represent significant guides to patient management in many clinical situations. "Negatives" may help rule out suspected abnormalities over a broad clinical range and are important for the patient's record.

AMES COMPANY
Division Miles Laboratories, Inc.
Elkhart, Indiana 46514

Ames

Note: *AMERICAN HOSPITAL FORMULARY SERVICE CATEGORY NUMBER 36:88*

40167

National and Regional Meetings in Florida

December

American Academy of Orthopaedic Surgeons, Bayfront Auditorium, Miami, Dec. 1-3.

January

AMA First International Conference on Prematurity, Pier 66, Lago Mar, Marina Motor Inn, Fort Lauderdale, Jan. 11-13.

April

American Radium Society, Fontainebleau Hotel, Miami Beach, Apr. 7-11.

American Broncho-Esophagological Association, Hollywood Beach Hotel, Hollywood, Apr. 21-22.

American Cleft Palate Association, Deauville Hotel, Miami Beach, Apr. 25-27.

American Hospital Association, Hollywood Beach Hotel, Hollywood, Apr. 25-26.

American Laryngological Association, Hollywood Beach Hotel, Hollywood, Apr. 25-26.

American Laryngological, Rhinological and Otological Society, Hollywood Beach Hotel, Hollywood, Apr. 21-26.

The Duvall Home for Retarded Children

founded 1946; now operated by

United Presbyterian Special Services, Inc.

A non-profit charitable corporation; an agency of North Florida Presbytery of the United Presbyterian Church in the USA.

The Home continues to provide the finest custodial care with a happy homelike environment. We accept all ages and types of retardation.

Your inquiries and personal visits are invited.

William F. Hanks, Administrator
P. O. Box 36
Glenwood, Florida 32722

Tax Exempt *Non-Denominational* *Non-Profit*

Classified Advertisements

Advertising rates for this column are $5.00 per insertion for ads of 25 words or less. Add 20¢ for each additional word.

physicians wanted

General Practitioners

GENERAL PRACTITIONER WANTED (AAGP) for north Florida college town. Vacancy in busy two man practice in medicine, pediatrics and obstetrics. Immediate excellent income with eventual full partnership. Write C-614, P.O. Box 2411, Jacksonville, Fla. 32203.

EXCELLENT OPPORTUNITY for general practitioner in community of 15,000; central Florida; 76 bed JCAH hospital. Write or call collect R. C. Thompson, Bartow Memorial Hospital, Bartow, Fla.

WANTED: General practitioner associate, leading to partnership. Practice approximately one half industrial. Ideal central Florida community. Send detailed resume to C-716, P.O. Box 2411, Jacksonville, Fla. 32203.

WANTED: General practitioner to associate with established young doctor. Also office space available for rent. Contact G. L. Ehringer, M.D., 1184 Oceanshore Blvd., Ormond Beach, Fla. 32074.

WANTED: Physician, internal medicine preferred, for Rainbow Lakes Estates. Community mostly retirees, Marion County, Florida. Must have Florida license. Offer: air-conditioned office rent free and utilities furnished. House available. Three hospitals radius 30 miles. Write to Joseph D. Stearns, Rt. A-2, Box 66, Dunnellon, Fla. 32630.

WANTED: General practitioner or general surgeon to replace physician going to specialize. Good opportunity in ideal central Florida city. Excellent office and equipment. Write C-780, P.O. Box 2411, Jacksonville, Fla. 32203.

Specialists

OBSTETRICIAN-GYNECOLOGIST WANTED: To associate with two man group. Large established practice in Miami; Board eligible or certified; prefer under age 35. Write P.O. Box 384, Miami Shores, Fla. 33153.

INTERNIST WANTED: To associate with established internist in greater Miami area. Terms open. Attractive fringe benefits. Large, active practice. Write C-789, P.O. Box 2411, Jacksonville, Fla. 32203.

INTERNIST WANTED: Board qualified or certified to join two other certified internists in private practice. Share large suite, laboratory, x-ray and alternate calls. Call J. E. Gordon, M.D., Pompano Beach, Fla. (305)941-5629.

OBSTETRICIAN-GYNECOLOGIST wanted soon as associate or partner in a two office established practice in southeast Florida. Write C-792, P.O. Box 2411, Jacksonville, Fla. 32203.

ANESTHESIOLOGIST to join another in Florida coast resort clinic; 1,600 surgeries ½ major; 93% of fees; anticipated expansion to 500 beds; exceptional opportunity. Apply American Medical Personnel, 159 E. Chicago Ave., Chicago, Ill. 60611.

INTERNIST OR SURGEON wanted. Beautiful Lake Wales in central Florida is just completing a new 1.8 million dollar hospital addition. Several G.P.s, a pediatrician and an ob.-gynecologist are in practice here. We have a radiologist and good pathology coverage, but no residing internist or surgeon. A modern, new, ground floor, front, professional suite directly across from the new hospital is available for lease or corporate participation. We will make it easy for you to get started. Write C-794, P.O. Box 2411, Jacksonville, Fla. 32203.

Locum Tenens

LOCUM TENENS WANTED: Required immediately for general practice. Call (904) 677-2907 or write G. L. Ehringer, M.D., 1184 Ocean Shore Blvd., Ormond Beach, Fla. 32074.

Miscellaneous

INDUSTRIAL: Established clinic needs physician with some surgical and orthopedic training. Eventual partnership anticipated. Write The Mitchell Clinic, 241 W. Ashley St., Jacksonville, Fla. 32202.

INTERNIST or GENERAL PRACTITIONER wanted to join medical group or share space in suburban Miami. Write C. F. Lester, M.D., 8988 Bird Rd., Miami, Fla. 33165.

WANTED: Internist, board certified or eligible and general practitioner for long established group on southeast coast between Miami and Fort Lauderdale. Must have Florida license and completed military obligation. Guaranteed $18,000. per year. Potential much higher. Write John F. Kerwick, Manager, The Hollywood Clinic, P.O. Box 2308. Hollywood, Fla. 33022. If urgent, call collect 923-4646.

situations wanted

LOCUM TENENS: Third year ENT resident with 2 years general practice experience desires 2-3 weeks general practice or ENT locum tenens during January, February or March 1968, preferably February, in Broward or Palm Beach counties. Florida licensed. Write C-790, P.O. Box 2411, Jacksonville, Fla. 32203.

WANTED: Recently retired, certified surgical specialist, interested in part time administrative or executive position in Florida. Travel no bar. Age 65, health excellent, formerly president of large city society and of state association. Long experience on specialty board and past president of two national specialty societies. Retired captain (MC) U.S.N.R. and clinical professor in large midwestern medical school. Salary open for discussion. Write C-791, P.O. Box 2411, Jacksonville, Fla. 32203.

$100,000 investment possible. Physician, not Florida licensed, desires purchase of interest in extended care facility. Supervisory and administrative activities. First class facility, congenial co-owners and security of investment essential. Write C-786, P.O. Box 2411, Jacksonville, Fla. 32203.

Board certified general surgeon in North wishes to establish practice in Florida. Will consider general practice. Interested in solo, partnership or group. Write C-795, P.O. Box 2411, Jacksonville, Fla. 32203.

real estate

FOR LEASE: Beautiful new office space across street from modern three story hospital, going to five stories in the future. Will custom design interior. Write C-793, P.O. Box 2411, Jacksonville, Fla. 32203.

FOR RENT: Tampa. Office for specialist in new medical center adjacent new hospital. Abundant parking, very accessible, three treatment rooms, consultation room. About 800 sq. ft. Share space with dentist. Write C-787, P.O. Box 2411, Jacksonville, Fla. 32203.

FOR RENT: New professional office, only one on Singer Island. Ready about January. S. F. Holden, Inc., 1265 Plaza Circle, Riviera Beach, Fla. 33404. Phone 842-1441.

AVAILABLE IMMEDIATELY: Office building and equipment for rent or lease. Spacious nine rooms for general practice and surgery. Due to illness, owner retired after 39 years of practice in Gainesville, Florida. Write: John E. Maines Jr., M.D., 317 N.E. First St., Gainesville, Fla. 32601.

Miscellaneous

FOR SALE: By distributor—Electronic telephone answering and recording equipment. Eliminates answering services. No installation. Fully transistorized. Utilizes voice induction—high fidelity. Performs dictaphone services. Tax deductible. Comparatively low cost. American made. Guaranteed. Specifications and prices furnished without obligation. No salesman. Wellington House, City Hall, 107 Ventura, Ojai, Calif. 93023.

FOR SALE: Instruments for use by aviation medical examiner. Brand new. Maddox rod, Risley rotary prism and Ishihara color chart. Frank P. Tocci, M.D., 1101 E. Broward Blvd., Ft. Lauderdale, Fla. 33301.

The Florida Medical Association offers placement assistance through the Physician Placement Service, P.O. Box 2411, Jacksonville 32203. This service is for the use of physicians seeking locations, as well as physicians seeking associates, and is without charge.

Deadline Nears For Annual Meeting Scientific Papers and Exhibits

Applications are now being accepted for scientific papers and exhibits to be presented before the 94th Annual Meeting of the Florida Medical Association, May 9-12 at the Diplomat Hotel, Hollywood Beach. Application forms will be included in the Briefs newsletter. Additional applications may be obtained by writing Russell B. Carson, M.D., Chairman, Committee on Scientific Assemblies, P.O. Box 2411, Jacksonville, Florida 32203.

Applications must be submitted no later than January 1, 1967. The Committee on Scientific Assemblies will make selections and notify contributors of acceptance shortly thereafter.

Important Note: All applications for scientific papers to be presented before the 94th Annual Meeting of the Florida Medical Association must be accompanied by a one page (200 word) summary of the paper prepared for publication in the Journal of the Florida Medical Association. Summaries of accepted papers will be published in the Journal prior to the Annual Meeting.

HIGHLAND HOSPITAL

ASHEVILLE, NORTH CAROLINA

Founded 1904

A DIVISION OF THE DEPARTMENT OF PSYCHIATRY
OF DUKE UNIVERSITY

Accredited by the Joint Commission on Accreditation and Certified for Medicare

Complete facilities for evaluation of and intensive treatment of psychiatric patients, including individual psychotherapy, group therapy, psychodrama, electro-convulsive therapy, Indoklon convulsive therapy, drugs, social service work with families, family therapy, and an extensive and well organized activities program, including occupational therapy, art therapy, athletic activities and games, recreational activities and outings. The treatment program of each patient is carefully supervised in order that the therapeutic needs of each patient may be realized.

Complete modern facilities with 85 acres of landscaped and wooded grounds in the City of Asheville.

Brochures and information on financial arrangements available
Contact: Mrs. Elizabeth Harkins, ACSW, Coordinator of Admissions

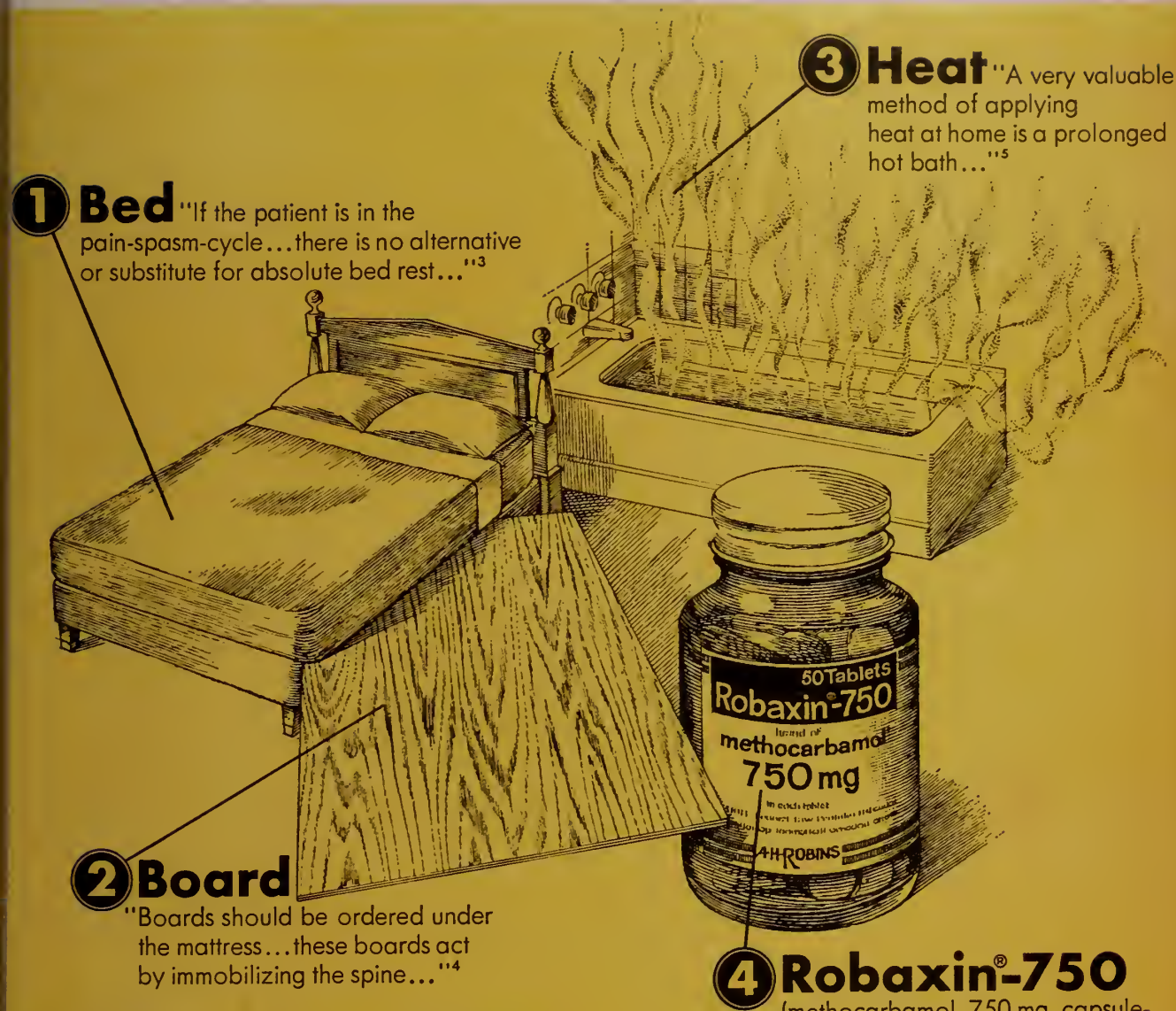
or

Charles W. Neville, Jr., M.D.
Assistant Professor of Psychiatry and Medical Director
Area Code 704 - 253-2761

LOW-BACK PAIN

A CONSERVATIVE, FOUR-POINT PROGRAM

The low back pain that is most frequently seen in general practice is mechanical in nature, i.e., postural back pain, joint dysfunction and acute back strain.[1,2] For this type of discomfort, a conservative regimen is usually sufficient to relieve aches and pains, and to help keep the patient functioning. Components of this basic program include:



1 Bed "If the patient is in the pain-spasm-cycle...there is no alternative or substitute for absolute bed rest..."[3]

2 Board "Boards should be ordered under the mattress...these boards act by immobilizing the spine..."[4]

3 Heat "A very valuable method of applying heat at home is a prolonged hot bath..."[5]

4 Robaxin®-750 (methocarbamol, 750 mg. capsule-shaped tablets) A well-tolerated[6] skeletal muscle relaxant, methocarbamol helps relieve spasm "...without interfering with normal tone and movement."[7] And there is little likelihood of sedation.[6]

Indicated for relief of skeletal muscle spasm. **Contraindicated** in hypersensitive patients. **Side Effects** (lightheadedness, dizziness, drowsiness, nausea) may occur rarely, but usually disappear on reduced dosage. Hypersensitivity reactions develop infrequently. See product literature for further details. **Also available:** Robaxin® Tablets (methocarbamol, 500 mg.) Robaxin Injectable (methocarbamol, 1 Gm./10 cc.)

References: (1). Gadfrey, C.M.: Applied Therap. 8:950, 1966. (2). Gattscholk, L.A.: GP 33:91, 1966. (3). Rowe, M.L.: J. Occup. Med. 2:219, 1960. (4). Cazen, L.: South Dakata J. Med. 18:26, 1965. (5). Sota-Hall, R.: Med. Sc. 14:23, 1963. (6). Weiss, M. and Weiss, S.: J. Am. Osteapath. A. 62:142, 1962. (7). Feuer, S.G., *et al.*: New York J. Med. 62:1985, 1962.

A·H·ROBINS A. H. ROBINS COMPANY RICHMOND, VIRGINIA 23220



"Yes, Doctor, the pain is gone."

'EMPIRIN'® COMPOUND with CODEINE PHOSPHATE gr. 1/2 No. 3

Each tablet contains: Codeine Phosphate gr. ½ (Warning—May be habit forming), Phenacetin gr. 2½, Aspirin gr. 3½, Caffeine gr. ½.

■ Despite introduction of synthetic substitutes, efficacy of 'Empirin' Compound with Codeine remains unchallenged.

BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N.Y.

When the talk turns to oral contraceptives, it makes medical sense to remember low-dose Norinyl®-1.

(norethindrone 1mg. & mestranol 0.05mg.)

Turn page for contraindications, precautions and side effects.



Reduction of oral contraceptive dosage to the lowest effective levels is a well-accepted principle of conservative medical practice. In keeping with this view, Norinyl is now also available as Norinyl-1, containing exactly one half the previous dosage of norethindrone and mestranol. Clinical experience has established that effective fertility control can be achieved with the same degree of reliability and safety with new Norinyl-1 when taken as directed.

What about switching patients from higher dosage forms?

In transferring patients to low-dose Norinyl-1 from higher-dosage oral contraceptives, some breakthrough bleeding may occur in the early cycles. In the majority of cases the bleeding episode is mild and self-limited. The long-term advantages of the lower dosage form should be weighed against the inconvenience of possible breakthrough bleeding in the individual patient.

Prescribing Information

Contraindications: Patients with any symptoms or history of thrombophlebitis, pulmonary embolism, liver dysfunction or disease, carcinoma of breast or genital organs, or undiagnosed vaginal bleeding.

Warnings: Discontinue medication pending examination if there is sudden partial or complete loss of vision, proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions, medication should be withdrawn. The safety of Norinyl-1 in pregnancy has not been demonstrated. If a patient misses two consecutive periods, pregnancy should be ruled out before continuing the medication. If she has not adhered to the prescribed schedule, pregnancy should be considered at the first missed period. Active ingredients of oral contraceptives have been detected in the milk of mothers who received these drugs; the significance to infants has not been determined.

Precautions: Pretreatment physical should include examination of the breasts and pelvic organs, as well as a Papanicolaou smear. If endocrine or liver function tests are abnormal during therapy, repeat tests are recommended after the drug has been withdrawn for two months. Following administration of drug, preexisting uterine fibromyomata may increase in size. Careful observation and caution are required for patients with symptoms or history of epilepsy, migraine, asthma, cardiac or renal dysfunction, cerebrovascular accident, psychic depression, and diabetes. In cases of undiagnosed vaginal bleeding, adequate diagnostic measures are indicated. Possible long-term effects of the drug on pituitary, ovarian, adrenal, hepatic or uterine function must await further studies. The physician should be alert to the earliest manifestations of thrombophlebitis and pulmonary embolism. The drug should be used judiciously in those young patients in whom bone growth is not complete. The age of the patient constitutes no absolute limiting factor, although treatment with Norinyl-1 may mask symptoms of the climacteric. The pathologist should be advised of Norinyl-1 therapy when relevant specimens are submitted.

Side Effects: The following have been observed with varying incide in patients receiving oral contrace tives: nausea, vomiting, gastroint tinal symptoms, breakthrough bleeding, spotting, change in menstrual flow, amenorrhea, ede chloasma or melasma, breast chan (tenderness, enlargement and secretion), change in weight (increa or decrease), changes in cervical erosion and cervical secretions, suppression of lactation when give immediately postpartum, cholesta jaundice, migraine, rash (allergic), rise in blood pressure in susceptibl individuals, mental depression. Although the following side effect have been reported in users of oral contraceptives, no cause and effect relationship has been established: anovulation posttreatment, preme struallike syndrome, changes in libido, changes in appetite, cystitis like syndrome, headache, nervous ness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme, erythema nodosum, hemorrhagic eruption, a itching. The following occurrences have been observed in users of ora contraceptives (a cause and effect relationship has neither been estab lished nor disproved): thrombophlebitis, pulmonary embolism, neuroocular lesions.

The following laboratory tests ma be altered by the use of oral contra ceptives: increased sulfobromophthalein and other hepatic functi tests, coagulation tests (increase i prothrombin, factors VII, VIII, IX and X), thyroid function (increase PBI and butanol extractable protei bound iodine and decrease in T^3 values), metyrapone test, pregnanediol determination.

norethindrone — an original steroid from
SYNTEX
LABORATORIES INC., PALO ALTO, CALIF.

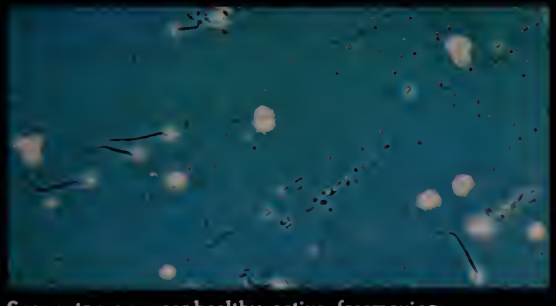
Here's why Norinyl-1 makes medical sense.

The effectiveness of Norinyl-1 as a low-dose oral contraceptive may be explained by its possible multiple action. In addition to its primary action of suppression of ovulation, Norinyl-1 may offer additional protective mechanisms... (1) creation of a cervical mucus that may be hostile to sperm penetration, and (2) development of an endometrium that may be out of phase with nidation. These effects are illustrated below.

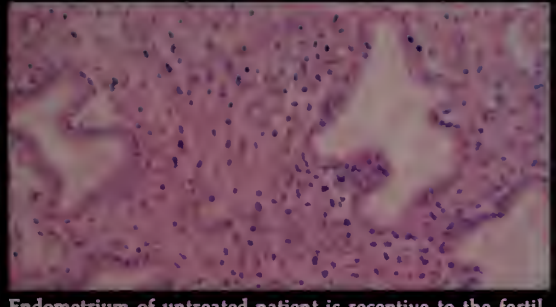
Untreated Patient



Cervical mucus at midcycle is usually thin and watery, with Spinnbarkeit (stretchability) of 15 to 20 cm.



Spermatozoa appear healthy, active, freemoving.

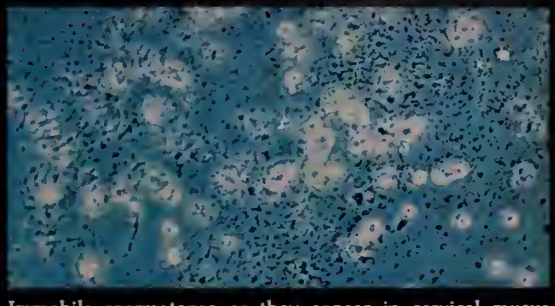


Endometrium of untreated patient is receptive to the fertilized ovum during secretory phase.

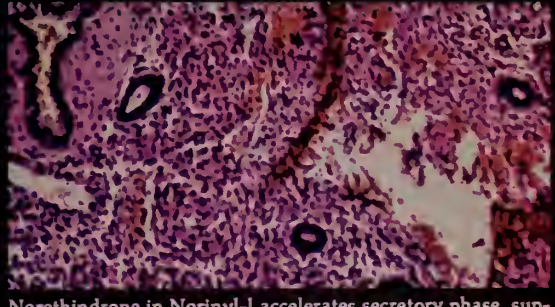
Norinyl-1 Patient



Cervical mucus at midcycle is scanty, viscous—with Spinnbarkeit of 1 cm. or less.



Immobile spermatozoa as they appear in cervical mucus taken from patient treated with Norinyl-1.



Norethindrone in Norinyl-1 accelerates secretory phase, suppresses glandular and vascular development.

Norinyl®-1
(norethindrone 1mg. & mestranol 0.05mg.) tablets

- new low dose of time-proved ingredients
- established norethindrone/mestranol ratio
- lower patient cost

An uncommon steroid for common inflammatory dermatoses

In everyday topical steroid therapy, Synalar produces rapid resolution of inflammation and itching in steroid-responsive dermatoses—and at relatively low cost to the patient.

Advanced molecular design enhances potency

Synalar combines the advantage of earlier corticosteroid compounds with unique structural innovations. As a result, preparations of Synalar 0.01% and Synalar 0.025% have been reported to be more potent topically and significantly more effective than hydrocortisone 1.0%. The unique fluocinolone acetonide molecule provides one of the most useful topical corticosteroids for everyday practice.

Impressive clinical results in a wide range of dermatologic problems

The clinical efficacy of Synalar has been extensively documented in the world literature. Commonly encountered diseases such as allergic and contact dermatitis, eczematous and seborrheic dermatitis, and neurodermatitis respond rapidly to Synalar, often where previous therapy with other topical corticosteroids has failed.

Low patient cost for wider usefulness

With Synalar, a high degree of efficacy does not mean high price. And—a small quantity goes a long way. Thus, your patients can often obtain the "economy" of a hydrocortisone preparation with the proved efficacy of a potent, truly advanced steroid.

Synalar®
fluocinolone acetonide





Turn page for contraindicat[illegible] precautions and side effe[illegible]

For everyday topical steroid therapy

Synalar® 0.01%

fluocinolone acetonide provides economy in two practical dosage forms

For general use, the most economical and widely applicable concentration of Synalar is 0.01% Cream in a water-washable, vanishing cream base. Synalar Solution 0.01% is especially valuable in dermatoses involving moist, intertriginous areas or hairy sites where creams and ointments do not spread or penetrate readily. Synalar Solution is a unique dosage form—clear, nongreasy, cosmetically elegant.

Product Information

Contraindications: Tuberculous, fungal, and most viral lesions of the skin (including herpes simplex, vaccinia, and varicella). Not for ophthalmic use. Contraindicated in individuals with a history of hypersensitivity to any of the components. *Precautions:* Synalar preparations are virtually nonsensitizing and nonirritating. However, the solution may produce burning or stinging when applied to denuded or fissured areas. In some patients with dry lesions, the solution may increase dryness, scaling or itching. Where severe local infection or systemic infection exists, the use of systemic antibiotics should be considered, based on susceptibility testing. While topical steroids have not been reported to have an adverse effect on pregnancy, the safety of their use on pregnant females has not absolutely been established. Therefore, they should not be used extensively on pregnant patients, in large amounts, or for prolonged periods of time. *Side Effects:* Side effects are uncommon with topical corticosteroids. As with all drugs, however, a few patients may react unfavorably to Synalar under certain conditions. In such cases the agent should be discontinued and appropriate measures taken. *Availability:* Synalar (fluocinolone acetonide) Cream 0.025%—5, 15 and 60 Gm. tubes and 425 Gm. jars. Cream 0.01%—15, 45 and 60 Gm. tubes and 120 Gm. jars. Solution 0.01%—20 and 60 cc. plastic squeeze bottles. Ointment 0.025%—15 and 60 Gm. tubes. Neo-Synalar® (neomycin sulfate 0.5% [0.35% neomycin base], fluocinolone acetonide 0.025%) Cream—5, 15 and 60 Gm. tubes.

fluocinolone acetonide—an original steroid from

SYNTEX

LABORATORIES INC. PALO ALTO, CALIF



Florida Organizations of Medical Interest
Meetings and Officers

ORGANIZATION	PRESIDENT	SECRETARY	ANNUAL MEETING
ida Medical Association	W. Dean Steward, Orlando	Floyd K. Hurt, Jacksonville	Hollywood, May 8-12, 1968
lorida Specialty Societies			
rgy Society	George Gittelson, Miami	Melvin Newman, Jacksonville	
sthesiologists, Soc. of	Henry J. Vomacka, Sarasota	George T. Edwards, Ft. Lauderdale	
st Phys., Am. Coll., Fla. Chap.	Harold C. Spear, Miami	Charles H. Lasley, Clearwater	
matology, Society of	Helen L. Dexter, Clearwater	Arnold R. Goddard, Coral Gables	
eral Practice, Academy	Louis C. Murray, Orlando	William P. Clarke, Jacksonville	
rnal Medicine	Robert E. Raborn, Delray Beach	Abbott Y. Wilcox Jr., St. Petersb'g	
rology, Florida Society of	J. Robert Campbell, Tampa	Francis L. Merritt, Lakeland	
rosurgical Society	Purdue L. Gould, West Palm Bch.	Howard C. Chandler, Jacksonville	
t. & Gynec. Society	Davis H. Vaughan, Clearwater	Joseph W. Pilkington, St. Petersb'g	
thalmology Society	James W. Clower Jr., D'tona Bch.	Charles F. McCrory, Jacksonville	
opedic Society	Leon H. Mims Jr., Coral Gables	Robert J. Pfaff, Lakeland	
laryngology Society	Bernard M. Barrett, Pensacola	West Bitzer, Ocala	
hologists, Society of	Laudie E. McHenry Jr., Melb. Bch.	William F. Mahoney, Sarasota	
iatric Society	James M. Weaver, Ft. Lauderdale	Ray O. Edwards Jr., Jacksonville	
s. Med. & Rehab., Fla. Soc.	Sterling H. Huntington, Coral Gbls.	Bruce B. Sutton, Coral Gables	
tic & Reconstr. Surg.	Thomas J. Baker, Miami	Robert L. Wells, St. Petersburg	
ventive Medicine, Fla. Soc.	Charles C. Flood, Vero Beach	E. Charlton Prather, Orange Park	
ctologic Society	George Williams Jr., Miami	John T. McCormick, Jacksonville	
chiatric Society	William C. Ruffin Jr., Gainesville	Arnold H. Eichert, Ft. Lauderdale	
iological Society	Andre S. Capi, Fort Lauderdale	Malcolm S. Van de Water, P. Bch.	
geons, Am. Coll., Fla. Chap.	Richard G. Connar, Tampa	Harry W. Reinstine Jr., J'ville	
geons, Gen., Fla. Assn.	Robert E. Zellner, Orlando	Jesse W. Castleberry, Orlando	
geons, Int. Coll., Fla. Chap.	Eldridge W. Johnson, Orlando	Wendell J. Newcomb, Pensacola	
logical Society	Carey N. Barry, Fort Myers	Victor A. Politano, Miami	
FLORIDA			
erican Cancer Society, Div.	John J. Fomon, M.D., Miami	Mrs. Peggy Lombardo, J'ville	Ft. Lauderdale, Nov. 8-10, '68
hritis Foundation, Chap.	Mr. John S. Knotts, Daytona Bch.	Miss Barbara White, G'ville	April 1968
ic Science Examining Board	Paul A. Vestal, Ph. D., Winter Pk.	Theodore A. Ashford, Ph.D. 1832 Bearss Ave., Tampa 33612	Coral Gables, June 1, '68
od Banks, Association	A. Ralph Monaco, M.D., Panama City	Dorothy C. Smith, R.N., J'ville	Pensacola, Apr. 26-28, '68
e Shield of Florida, Inc.	Warren W. Quillian, M.D., Coral Gables	Henry J. Babers Jr., M.D., Gainesville	Hollywood, May 8-12, '68
ard of Medical Examiners	Madison R. Pope, M.D., Plant City	Scheffel H. Wright, M.D., Miami P.O. Box 5, Biscayne Annex, Miami 33152	Jacksonville, Jan. 14-16, '68
ppled Children & Adults, Soc.	Mr. John W. McWhirter Jr., Tampa	Mr. David S. Walker Jr., Miami	Daytona Beach, Fall 1968
betes Association	William C. Thomas Jr., M.D., Gainesville	George P. Heffner, M.D., Ft. Lauderdale	Miami Beach, Oct. 1, '68
art Association	Louis Lemberg, M.D., Miami	Mr. Philip F. Ashler, Pensacola	Miami, June 7-9, '68
ntal Health, Association for	Moke W. Williams, M.D. Ft. Lauderdale	Mrs. R. R. Littrell, Sarasota	Cocoa Beach, Apr. 25-27, '68
tional Foundation	Mr. Basil O'Connor, New York	Mr. Ed. Foreman, Orlando	April 1968
t'l Multiple Sclerosis Soc.	Mr. Harold W. Comfort, New York	Mr. Robert E. McWeeney, H'wood	
evention of Blindness, Soc.	Mr. R. B. Matthews, Coral Gables	Mrs. Richard Nosti, Tampa	Tampa, Nov. 1968
blic Health Association	William R. Stinger, M.D., Miami	Mrs. Margaret McLendon, J'ville	
tarded Children, Association	Mr. Marion P. Smith, Clearwater	Mrs. Jane Riedel, Cocoa	Clearwater, May 9-12, '68
oracic Society	Asher Marks, M.D., Miami	Edward W. Swenson, M.D., Gainesville	April 1968
berculosis & Res. Dis. Assn.	Mr. R. A. Caruthers, Orlando	Mr. C. W. Lantz, Hollywood	April 1968
ited Cerebral Palsy of Florida	Mr. John P. Hilburn, Tampa	Mr. Harry Botwick, Miami	November 1968
oman's Auxiliary	Mrs. Russell B. Carson, Ft. Lauderdale	Mrs. Linus W. Hewit, Tampa	Hollywood, May 8-12, '68

(Most Specialty Group meetings are scheduled at the time of the annual meeting of the Association)

Florida Medical Association

1967-1968

Officers, Councils and Committees

OFFICERS

W. DEAN STEWARD, M.D., President Orlando
JACK Q. CLEVELAND, M.D.,
President-Elect Coral Gables
IRVING E. HALL JR., M.D.,
Vice President Bradenton
JAMES T. COOK, M.D.,
Speaker of the House Marianna
CHARLES K. DONEGAN, M.D.,
Vice Speaker St. Petersburg
FLOYD K. HURT, M.D.,
Secretary-Treasurer Jacksonville
GEORGE S. PALMER, M.D.,
Immediate Past President Tallahassee

EXECUTIVE DIRECTOR

W. HAROLD PARHAM Jacksonville

BOARD OF GOVERNORS

W. DEAN STEWARD, M.D.,*
Chm., Ex Officio Orlando
JACK Q. CLEVELAND, M.D.,*
(President-Elect) Ex Officio Coral Gables
IRVING E. HALL JR., M.D.,
(Vice President) Ex Officio Bradenton
JAMES T. COOK, M.D., (Speaker
of the House) Ex Officio Marianna
FLOYD K. HURT, M.D.,* (Secretary-
Treasurer) Ex Officio Jacksonville
GEORGE S. PALMER, M.D.,*+ ... PP-69 ... Tallahassee
H. PHILLIP HAMPTON, M.D., ... PP-68 ... Tampa
JOHN J. CHELEDEN, M.D., ... AL-68 ... Daytona Beach
WILLIAM M. C. WILHOIT, M.D., ... A-70 ... Pensacola
WILLIAM J. DEAN, M.D.,* ... B-71 ... St. Petersburg
CHARLES R. SIAS, M.D., ... C-69 ... Orlando
RICHARD M. FLEMING, M.D., ... D-68 ... Miami Beach
BURNS A. DOBBINS, M.D., ... AMA
Delegate-68 Ft. Lauderdale
EUGENE G. PEEK JR., M.D., ... SBH-68 ... Ocala

**Executive Committee*
+Public Relations Officer

Subcommittees to the Board:

Inter-American Relations
DAVID A. OHLWILER, M.D., Chm. *Winter Park*
WILLIAM P. CLARKE, M.D., Vice Chm. ... *Jacksonville*
JOHN J. FISHER, M.D. *Jacksonville*
LOUIS P. BRADY, M.D. *Orlando*
JACOB R. ROZIER, M.D. *Winter Park*
RICHARD P. SCHMIDT, M.D. *Gainesville*
WILSON T. SOWDER, M.D. *Jacksonville*

Quackery
MILLARD P. QUILLIAN, M.D., Chm. *Bradenton*
WILLIAM A. MULFORD, M.D. *Green Cove Springs*
JOHN H. MICKLEY, M.D. *Hollywood*
EDWARD L. COLE, M.D. *St. Petersburg*
M. EUGENE FLIPSE, M.D. *Coral Gables*

Venomous Snake Bite
CARL E. ANDREWS, M.D., Chm. *West Palm Beach*
L. WASHINGTON DOWLEN, M.D. *Miami*
RAY O. EDWARDS JR., M.D. *Jacksonville*
KENNETH W. JACKSON, M.D. *Lake Alfred*
JOHN E. DEES, M.D. *Miami*

COUNCIL ON ALLIED PROFESSIONS AND VOCATIONS

JESSE W. CASTLEBERRY, M.D., Chm. *Orlando*

DENTISTRY
WILLIAM M. DOUGLAS, M.D., Chm. .. C-71 *Orlando*
GROVER W. AUSTIN, M.D., .. AL-68 *St. Petersburg*
W. ROY HANCOCK, M.D., .. A-68 *Jacksonville*
ARGIN A. BOGGUS, M.D., .. B-70 *Tavares*
JAMES G. ROBERTSON, M.D. .. D-69 *Miami*

LAW
HILBERT A. P. LEININGER, M.D.,
Chm. .. D-71 *Coral Gables*
AMOS L. PREVATT, M.D., .. AL-68 *Pensacola*
GERALD D. N. BRYANT, M.D., .. A-70 *Tallahassee*
JAMES R. BOULWARE JR., M.D., .. B-69 *Lakeland*
CARROLL M. CROUCH, M.D., .. C-68 *Daytona Beach*

MEDICAL ASSISTANTS
WOODS A. HOWARD, M.D., Chm. .. AL-68 *Lakeland*
SAMUEL J. ALFORD, M.D. .. A-71 *Jacksonville*
JAMES M. STEM, M.D., .. B-70 *Clearwater*
FRED H. ALBEE JR., M.D., .. C-69 *Daytona Beach*
JAMES L. ANDERSON, M.D. .. D-68 *Miami*

MEDICAL TECHNOLOGISTS
MILLARD B. WHITE, M.D., Chm. .. B-71 *Sarasota*
LAUDIE E. McHENRY JR., M.D.,
AL-68 *Melbourne Beach*
SANFORD A. MULLEN, M.D. .. A-70 *Jacksonville*
HAMPTON L. SCHOFIELD JR., M.D.,
C-69 *Vero Beach*
JOHN B. MIALE, M.D. .. D-68 *Miami*

NURSING
JAMES W. WALKER, M.D., Chm. .. A-68 *Jacksonville*
CHARLES H. GILLILAND, M.D., .. AL-68 *Gainesville*
JOHN M. BUTCHER, M.D., .. B-69 *Sarasota*
THOMAS C. KENASTON JR., M.D., .. C-71 *Cocoa*
JAMES J. HUTSON, M.D., .. D-70 *Miami*

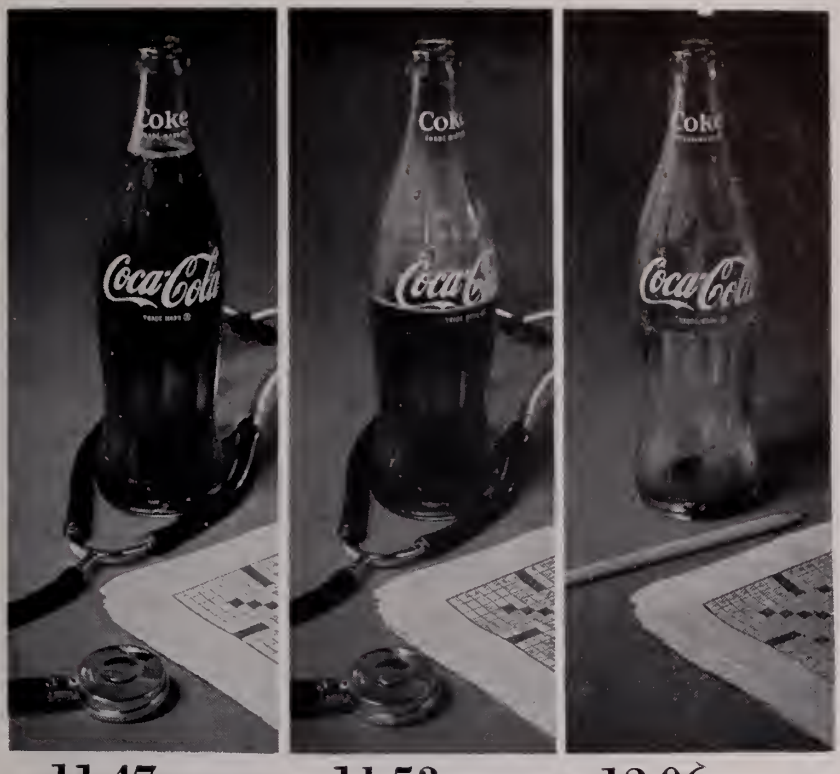
PHARMACY
BEN C. STOREY, M.D., Chm. .. C-71 *Titusville*
THOMAS D. WEAVER, M.D., .. AL-68 *Clermont*
GRETCHEN V. SQUIRES, M.D., .. A-68 *Pensacola*
JOSEPH A. EZZO, M.D., .. B-69 *St. Petersburg*
M. JAY FLIPSE, M.D., .. D-70 *Miami*

PHYSICAL THERAPY
WILLIAM J. HUTCHISON, M.D.,
Chm. .. AL-68 *Tallahassee*
JOSEPH C. SHIPP, M.D., .. A-68 *Gainesville*
ARTHUR J. PASACH, M.D., .. B-69 *Tampa*
LOUIS J. NOVAK, M.D., .. C-70 *Hollywood*
STERLING H. HUNTINGTON, M.D., .. D-71 .. *Coral Gables*

RELIGION
G. DEKLE TAYLOR, M.D., Chm. .. AL-68 *Jacksonville*
GRETCHEN V. SQUIRES, M.D., .. A-69 *Pensacola*
SIDNEY GRAU, M.D., .. B-70 *St. Petersburg*
CURTIS D. BENTON JR., M.D., .. C-71 *Ft. Lauderdale*
CORREN P. YOUMANS, M.D., .. D-68 *Miami*

VETERINARY MEDICINE
HIRAM C. POLK JR., M.D. Chm. .. D-71 *Miami*
JOHN H. PARKER JR., M.D., .. AL-68 *Perry*
GEORGE W. KARELAS, M.D., .. A-70 *Newberry*
IRWIN S. LEINBACH, M.D., .. B-69 *St. Petersburg*
JAMES C. RINAMAN, M.D. .. C-68 *St. Cloud*

RADIOLOGIC AND NUCLEAR MEDICINE TECHNOLOGISTS
EDWARD C. BURNS JR., M.D., Chm. .. AL-68 .. *Lake Wales*
ALEXANDER GOULARD JR., M.D., .. A-69 *Ocala*
BYRON E. BESSE JR., M.D., .. B-68 *Tampa*
HERBERT D. KERMAN, M.D., .. C-70 *Daytona Beach*
WILLIAM J. WINTER JR., M.D., .. D-71 *Miami*



11:47 pm 11:53 pm 12:06 am

The meaningful pause. The energy it gives. The bright little lift. Coca-Cola with its never too sweet taste, refreshes best. Helps people meet the stress of the busy hours. This is why we say **things go better with Coke**
TRADE-MARK ®

Hill Crest
HOSPITAL
(Formerly Hill Crest Sanitarium)

7000 5TH AVENUE SOUTH
Box 2896, Woodlawn Station
Birmingham, Alabama 35212
Phone: 205 - 836-7201

A patient centered independent hospital for intensive treatment of nervous disorders . . .

Hill Crest Hospital was established in 1925 as Hill Crest Sanitarium to provide private psychiatric treatment of nervous or mental disorders. Individual patient care has been the theme during its 42 years of service.

Both male and female patients are accepted and departmentalized care is provided according to sex and the degree of illness.

In addition to the psychiatric staff, consultants are available in all medical specialities.



MEDICAL DIRECTOR:
James A. Becton, M.D., F.A.P.A.

CLINICAL DIRECTORS:
James K. Ward, M.D., F.A.P.A.
Hardin M. Ritchey, M.D., F.A.P.A.

HILL CREST is a member of:
AMERICAN HOSPITAL ASSOCIATION . . . NATIONAL ASSOCIATION OF PRIVATE PSYCHIATRIC HOSPITALS . . . ALABAMA HOSPITAL ASSOCIATION . . . BIRMINGHAM REGIONAL HOSPITAL COUNCIL.
Hill Crest is fully accredited by the Joint Commission on Accreditation of Hospitals.

Hill Crest
HOSPITAL
BIRMINGHAM, ALABAMA

JUDICIAL COUNCIL

JOHN J. CHELEDEN, M.D., Chm. *Daytona Beach*

ARCHIVES

WILLIAM M. STRAIGHT, M.D., Chm. .. D-70 *Miami*
ROWLAND E. WOOD, M.D...AL-68..... *St. Petersburg*
JOSEPH P. HENDRIX, M.D., .. A-71 *Port St. Joe*
W. WARDLAW JONES, M.D., .. B-69 *Dade City*
HUGH WEST, M.D...C-68..... *DeLand*

GRIEVANCE

ROBERT E. ZELLNER, M.D., Chm. *Orlando*
WARREN W. QUILLIAN, M.D. *Coral Gables*
SAMUEL M. DAY, M.D. *Jacksonville*
H. PHILLIP HAMPTON, M.D. *Tampa*
GEORGE S. PALMER, M.D. *Tallahassee*

MEDICAL LICENSURE

COURTLANDT D. BERRY, M.D., Chm..... *Naples*
MADISON R. POPE, M.D. *Plant City*
SCHEFFEL H. WRIGHT, M.D. *Miami*

MEMBERSHIP AND DISCIPLINE

District 1—WILLIAM C. ROBERTS, M.D., .. 71 *Panama City*
J. WAYNE HENDRIX, M.D.,..70..*Port St. Joe*
District 2—WILLIAM C. THOMAS SR., M.D., ..68 *Gainesville*
JAMES T. COOK, M.D., .. 69, Chm. ..*Marianna*
District 3—THOMAS M. IRWIN, M.D., .. 70 ..*Jacksonville*
HUGH A. CARITHERS, M.D.,..71..*Jacksonville*
District 4—W. WARDLAW JONES, M.D., .. 68 ..*Dade City*
JOHN J. CHELEDEN, M.D.,...70..*Daytona Beach*
District 5—THOMAS C. KENASTON SR., M.D....69 *Cocoa*
FRANK C. BONE, M.D., .. 71 *Orlando*
District 6—ERNEST R. BOURKARD, M.D., .. 68 ..*Tampa*
C. FRANK CHUNN, M.D., .. 69 *Tampa*
District 7—GORDON H. McSWAIN, M.D., .. 71 ...*Arcadia*
JOHN M. BUTCHER, M.D., .. 70*Sarasota*
District 8—EDWARD L. COLE JR., M.D., .. 69 *St. Petersburg*
N. WORTH GABLE, M.D...68...*St. Petersburg*
District 9—WILLIAM H. PROCTOR, M.D., .. 70 *West Palm Beach*
MYRL SPIVEY, M.D., .. 71 ..*West Palm Beach*
District 10—MILES J. BIELEK, M.D., .. 71 ..*Ft. Lauderdale*
RUSSELL B. CARSON, M.D., .. 69 *Ft. Lauderdale*
District 11—EDWARD J. LAUTH JR., M.D., .. 68*Miami*
HAROLD RAND, M.D., .. 70*Miami*
District 12—JACK Q. CLEVELAND M.D...69...*Coral Gables*
NELSON ZIVITZ, M.D., .. 68*Miami Beach*

COUNCIL MEMBER FROM BOARD OF PAST PRESIDENTS

H. PHILLIP HAMPTON, M.D. *Tampa*

COUNCIL ON LEGISLATION AND PUBLIC AGENCIES

JERE W. ANNIS, M.D., Chm. *Lakeland*

STATE LEGISLATION

EDWARD G. HASKELL JR., M.D., Chm. .. A-70 *Tallahassee*
FRANK E. WILLIAMS, M.D., .. AL-68 *Cantonment*
JOHN E. OREBAUGH, M.D., .. B-71 *St. Petersburg*
LOUIS C. MURRAY, M.D., .. C-69 *Orlando*
ROBERT V. EDWARDS, M.D., .. D-68 *Coral Gables*

Subcommittee—Liaison with State Agencies:

FRANCIS T. HOLLAND, M.D., Chm. *Tallahassee*
SIMON D. DOFF, M.D., Commission on Aging ..*Jacksonville*
PAUL S. JARRETT, M.D., Alcoholic Rehabilitation ...*Miami*
EUGENE G. PEEK JR., M.D., Board of Health*Ocala*
MARION W. HESTER, M.D., Council for the Blind *Lakeland*
FRANCIS T. HOLLAND, M.D., Crippled Children's Commission *Tallahassee*
RAYMOND J. FITZPATRICK, M.D., Division of Correction *Gainesville*
WILLIAM M. C. WILHOIT, M.D., Division of Mental Health *Pensacola*
WESLEY S. NOCK, M.D., Education Department *Coral Gables*
THOMAS J. BIXLER, M.D., Industrial Commission *Tallahassee*
ARTHUR W. WOOD JR., M.D., Insurance Department *Miami*
JERE W. ANNIS, M.D., Public Welfare *Lakeland*
LAWRENCE E. GEESLIN, M.D., Tuberculosis Board *Jacksonville*
WILLIAM H. EVERTS, M.D., Vocational Rehabilitation *West Palm Beach*
CHARLOTTE C. MAGUIRE, M.D., Divisions of Youth Services and Mental Retardation *Orlando*

NATIONAL LEGISLATION

JOSEPH C. VON THRON, M.D., Chm. *Cocoa Beach*
JERE W. ANNIS, M.D. *Lakeland*
H. PHILLIP HAMPTON, M.D. *Tampa*
PHILIP B. PHILLIPS, M.D. *Pensacola*
EDWARD G. HASKELL JR., M.D. *Tallahassee*
SAMUEL M. DAY, M.D. *Jacksonville*
EUGENE G. PEEK JR., M.D. *Ocala*
CHARLES R. SIAS, M.D. *Orlando*
ROBERT W. WITHERS, M.D. *Tampa*
MELVIN M. SIMMONS, M.D. *Sarasota*
ALLYN B. GIFFIN, M.D. *St. Petersburg*
DAVID W. MARTIN, M.D. *West Palm Beach*
ANDRE S. CAPI, M.D. *Ft. Lauderdale*
JACK Q. CLEVELAND, M.D. *Coral Gables*
FRANKLIN J. EVANS, M.D. *Coral Gables*

Subcommittee—Liaison with Federal Agencies:

ROY E. CAMPBELL, M.D., Chm. *Palatka*
FRANK B. HODNETTE, M.D., Department of Defense *Pensacola*
JERE W. ANNIS, M.D., Department of Health, Education and Welfare *Lakeland*
ROBERT H. MICKLER, M.D., Department of Justice *Tallahassee*
THOMAS J. BIXLER, M.D., Department of Labor *Tallahassee*
ROY E. CAMPBELL, M.D., Veterans Administration *Palatka*

COUNCIL ON MEDICAL ECONOMICS

JACK A. MaCRIS, M.D., Chm. *St. Petersburg*

ADVISORY TO BLUE SHIELD & FISCAL INTERMEDIARIES

MYRL SPIVEY, M.D., Chm. .. C-71..... *West Palm Beach*
FRED A. BUTLER, M.D., .. AL-68..... *Naples*
JAMES D. BEESON, M.D., .. A-68..... *Jacksonville*
EDSON J. ANDREWS, M.D., .. A-69..... *Tallahassee*
RAYMOND J. FITZPATRICK, M.D., A-70 *Gainesville*
ALFRED L. LEWIS, M.D., .. A-71..... *Tallahassee*
IRVING M. ESSRIG, M.D.....B-68..... *Tampa*
RALPH C. AYE, M.D.,..... B-69..... *Tampa*
JOHN C. FLETCHER, M.D., .. B-70..... *Tampa*
HENRY G. MORTON, M.D., .. B-71..... *Sarasota*
LOUIS C. MURRAY, M.D., .. C-68..... *Orlando*
JACK T. BECHTEL, M.D., .. C-69..... *Indialantic*
JOHN R. MAHONEY, M.D., .. C-70..... *Ft. Lauderdale*
H. HOFFMAN GROSKLOSS, M.D., D-68 *Coral Gables*
HOLLIS F. GARRARD, M.D., .. D-69..... *Miami*
RICHARD C. CLAY, M.D., .. D-70..... *Miami*
JAMES L. ANDERSON, M.D.,.. D-71..... *Miami*

HEALTH INSURANCE

ARTHUR W. WOOD JR., M.D., Chm. .. AL-68 *Miami*
BILLY BRASHEAR, M.D...A-68..... *Gainesville*
GEORGE H. WELCH JR., M.D...B-71 *St. Petersburg*
ARTHUR L. EBERLY, M.D...C-70..... *Pompano Beach*
CHARLES A. MONNIN JR., M.D...D-69..... *Miami*

HOSPITALS AND EXTENDED CARE FACILITIES

VERNON B. ASTLER, M.D., Chm. .. AL-68 ..*Boynton Beach*
JOSEPH L. RUBEL, M.D...A-69..... *Pensacola*
EDWARD W. SALKO, M.D...B-71..... *Ft. Myers*
ALBERT F. STRATTON JR., M.D...C-68..... *Cocoa*
ROBERT F. DICKEY, M.D...D-70..... *Miami*

MEMBERS INSURANCE

W. ROY HANCOCK, M.D., Chm...A-68..... *Jacksonville*
H. LAWRENCE SMITH, M.D...AL-68..... *Tallahassee*
WILLIS W. HARRIS, M.D...B-71..... *Bradenton*
RUSSELL D. D. HOOVER, M.D...C-69....*West Palm Beach*
H. CLINTON DAVIS, M.D...D-70..... *Miami*

RELATIVE VALUE STUDIES

FRED A. BUTLER, M.D., Chm...B-71..... *Naples*
STUART C. SMITH, M.D...AL-68..... *Tallahassee*
JAMES A. CRANFORD JR., M.D...A-69..... *Jacksonville*
EMMET F. FERGUSON JR., M.D., .. A-70*Jacksonville*
CHARLES K. DONEGAN, M.D...B-70..... *St. Petersburg*
JOSEPH G. MATTHEWS, M.D...C-68..... *Orlando*
WILLIAM E. HOFFMEISTER, M.D., .. C-71 ..*Winter Park*
DUARD LAWRENCE, M.D...D-68..... *Miami*
FRANKLIN J. EVANS, M.D...D-69..... *Coral Gables*

Thomas B. Slade | Fifty Years in Florida | J. Beatty Williams

Surgical SUPPLY COMPANY

HAMILTON — RITTER — SKLAR — BURDICK
CLAY-ADAMS — B-D — BARD-PARKER — TYCOS
BAUM — WELCH-ALLYN AND MANY, MANY OTHERS

Ph. 355-8391 | P. O. Box 2580 — 1050 W. Adams Street | Jacksonville, Fla. 32203



P. L. DODGE MEMORIAL HOSPITAL

M. G. Isaacson, M.D.
Medical Director
1861 N.W. South River Drive
Miami, Florida
Phone 379-1448

A nonprofit-voluntary hospital for the treatment of nervous and mental disorders and the problems of drug addiction and alcoholic habituation. Modern diagnostic and treatment procedures including—Psychotherapy, Insulin, & Electroshock, when indicated. Adequate facilities for recreation and out-door activities. Admissions are made without regard to race, color or national origin.

Information on request
Member NAPPH, American Psychiatric Assn., & American Hospital Assn.

APPALACHIAN HALL

ASHEVILLE | Established 1916 | NORTH CAROLINA



An Institution for the diagnosis and treatment of Psychiatric and Neurological illnesses, rest, convalescence, drug and alcohol habituation.

Insulin Coma, Electroshock and Psychotherapy are employed. The Institution is equipped with complete laboratory facilities including electroencephalography and X-ray.

Appalachian Hall is located in Asheville, North Carolina, a resort town, which justly claims an all around climate for health and comfort. There are ample facillities for classification of patients, rooms single or en suite.

Wm. Ray Griffin Jr., M.D.
Robert A. Griffin, M.D

Mark A. Griffin Sr., M.D.
Mark A. Griffin Jr., M.D.

COUNCIL ON MEDICAL SERVICES

JAMES M. INGRAM, M.D., Chm.....*Tampa*

AGING

SIMON D. DOFF, M.D., Chm...AL-68.....*Jacksonville*
CHARLES J. KAHN, M.D...A-70.....*Pensacola*
JAMES A. WINSLOW JR., M.D...B-69.....*Tampa*
CLARENCE M. GILBERT, M.D...C-68.....*Orlando*
CHARLES R. BEBER, M.D...D-71.....*Miami*

BLOOD

FAIRFAX E. MONTAGUE, M.D., Chm...AL-68.....*Palatka*
GERARD H. HILBERT, M.D...A-70.....*Pensacola*
LEO E. REILLY, M.D...B-69.....*St. Petersburg*
JOHN H. MICKLEY, M.D...C-71.....*Hollywood*
O. WHITMORE BURTNER, M.D...D-68.....*Miami*

CHILD HEALTH

WESLEY S. NOCK, M.D., Chm...D-70.....*Coral Gables*
J. BASIL HALL, M.D...AL-68.....*Tavares*
THOMAS M. BRILL, M.D...A-69.....*Gainesville*
ADRIAN Q. POLLOCK, M.D...B-68.....*Ft. Myers*
IRWIN T. TAYLOR, M.D...C-71.....*Winter Park*

EMERGENCY MEDICAL SERVICE

JAMES L. CAMPBELL JR., M.D., Chm...C-68.....*Orlando*
A. T. KENNEDY, M.D...AL-68.....*Pensacola*
SAMUEL J. ALFORD JR., M.D...A-68.....*Jacksonville*
JOHN M. BUTCHER, M.D...B-68.....*Sarasota*
JOSEPH S. STEWART, M.D...D-68.....*Miami*

HEARING

JOHN H. WEBB, M.D., Chm...C-68.....*Orlando*
GEORGE T. SINGLETON, M.D...AL-68.....*Gainesville*
WILLIAM F. SHIPMAN JR., M.D...A-70.....*Tallahassee*
THOMAS M. EDWARDS, M.D...B-69.....*Tampa*
JAMES R. CHANDLER JR., M.D...D-71.....*Miami*

LABOR

LAURENT P. LaROCHE, M.D., Chm...AL-68....*Cocoa Beach*
ALBERT E. McQUAGGE, M.D...A-68.....*Marianna*
JAMES B. HODGE JR., M.D...B-71.....*Tampa*
THEODORE J. KAMINSKI, M.D...C-70.....*Melbourne*
JAMES J. HUTSON, M.D...D-69.....*Miami*

MATERNAL HEALTH

FRANK M. PARISH, M.D., Chm...AL-68.....*Orlando*
JAMES P. McNEIL JR., M.D...A-70.....*Jacksonville*
T. VERNON FINCH, M.D...B-68.....*Sarasota*
GROVER C. McDANIEL JR., M.D...C-69....*Ft. Lauderdale*
GUILLERMO A. PUENTE-DUANY, M.D...D-71.....*Miami*

MENTAL HEALTH

JAMES W. ETTINGER, M.D., Chm...C-68.....*Rockledge*
MERTON L. EKWALL, M.D...AL-68.....*Tallahassee*
WILLIAM M. C. WILHOIT, M.D...A-70.....*Pensacola*
ZACK RUSS JR., M.D...B-69.....*Tampa*
EDWARD H. WILLIAMS, M.D...D-71.....*Coral Gables*

MENTAL RETARDATION

CHARLOTTE C. MAGUIRE, M.D., Chm...C-68.....*Orlando*
C. JENNINGS DERRICK, M.D...AL-68....*West Palm Beach*
CHARLES R. BENTON, M.D...A-70.....*Pensacola*
RAY C. WUNDERLICH JR., M.D...B-71.....*St. Petersburg*
HERMAN SELINSKY, M.D...D-69.....*Miami Beach*

OCCUPATIONAL HEALTH

THOMAS B. THAMES, M.D., Chm...C-68.....*Orlando*
LAURENT P. LaROCHE, M.D...AL-68.....*Cocoa Beach*
SAMUEL S. LOMBARDO, M.D...A-69.....*Jacksonville*
CHARLES LARSEN JR., M.D...B-70.....*Lakeland*
JAMES J. HUTSON, M.D...D-71.....*Miami*

PUBLIC HEALTH

CLARENCE L. BRUMBACK, M.D.,
Chm...C-68.....*West Palm Beach*
FREDERICK C. ANDREWS, M.D...AL-68.....*Mount Dora*
JOHN B. BRITTON, M.D...A-69.....*Fernandina Beach*
ALBERT B. McCREARY, M.D...B-71.....*St. Petersburg*
JOHN D. MILTON, M.D...D-70.....*Coral Gables*

RURAL HEALTH

J. BASIL HALL, M.D., Chm...C-70.....*Tavares*
LAWRENCE G. HEBEL, M.D...AL-68.....*Palatka*
GEORGE W. KARELAS, M.D...A-68.....*Newberry*
FORREST HINTON, M.D...B-71.....*Immokalee*
RALPH E. CROSS, M.D...D-69.....*Homestead*

VISION

WILLIAM H. ANDERSON JR., M.D., Chm...A-71*Ocala*
G. BROCK MAGRUDER, M.D...AL-68.....*Orlando*
JOSEPH W. TAYLOR JR., M.D...B-70*Tampa*
CURTIS D. BENTON JR., M.D...C-69*Fort Lauderdale*
ALFRED G. SMITH II, M.D...D-68*Coral Gables*

COUNCIL ON SCIENTIFIC ACTIVITIES

RICHARD C. DEVER, M.D., Chm.....*Miami*

THE JOURNAL AND OTHER PUBLICATIONS

THAD MOSELEY, M.D., Editor.....*Jacksonville*
JOHN M. PACKARD, M.D., Assistant Editor.....*Pensacola*
OSCAR W. FREEMAN, M.D., Assistant Editor.....*Orlando*
JACK Q. CLEVELAND, M.D., Assistant Editor
from the Board of Governors.....*Coral Gables*

MEDICAL SCHOOLS

HENRY J. BABERS JR., M.D., Chm...A-71,
Alachua County Medical Society*Gainesville*
HENRY H. GRAHAM, M.D...AL-68*Gainesville*
SORRELL L. WOLFSON, M.D...B-69.....*Tampa*
FRED WALLS JR., M.D...C-68.....*Orlando*
EDWARD W. CULLIPHER, M.D...D-70,
Dade County Medical Association.....*Miami*
HAYDEN C. NICHOLSON, M.D., Faculty,
University of Miami.....*Miami*
SAMUEL P. MARTIN, M.D., Faculty,
University of Florida.....*Gainesville*

POSTGRADUATE EDUCATION

RICHARD G. CONNAR, M.D., Chm...B-70*Tampa*
JAMES J. DeVITO, M.D...A-71.....*St. Augustine*
MATTHEW E. MORROW JR., M.D...AL-68*Jacksonville*
CHARLES J. COLLINS, M.D...C-69.....*Orlando*
WILLIAM W. CLEVELAND, M.D...D-68.....*Miami*

RESEARCH

KARL B. HANSON, M.D., Chm...A.....*Jacksonville*
DONALD W. SMITH, M.D...AL.....*Miami*
MILLARD B. WHITE, M.D...B.....*Sarasota*
MARTIN G. GOULD, M.D...C.....*Ft. Pierce*
JAMES J. GRIFFITTS, M.D...D.....*Miami*

SCIENTIFIC ASSEMBLIES

RUSSELL B. CARSON, M.D., Chm...C-69....*Ft. Lauderdale*
CHARLES K. DONEGAN, M.D...AL-68*St. Petersburg*
GEROLD L. SCHIEBLER, M.D...A-68.....*Gainesville*
EDWIN T. LONG, M.D...B-71*Lakeland*
JEROME H. MODELL, M.D...D-70.....*Miami*

COUNCIL ON SPECIAL ACTIVITIES

JOHN D. MILTON, M.D., Chm.....*Coral Gables*

ADVISORY TO WOMAN'S AUXILIARY

LEE ROGERS JR., M.D., Chm...C-68.....*Rockledge*
RUSSELL B. CARSON, M.D...AL-68.....*Ft. Lauderdale*
GORDON H. IRA, M.D...A-71.....*Jacksonville*
EUGENE B. MAXWELL, M.D...B-69*Tampa*
PERRY D. MELVIN, M.D...D-70.....*Miami*

BOARD OF PAST PRESIDENTS

JOHN D. MILTON, M.D., Chm...1955.....*Coral Gables*
GEORGE S. PALMER, M.D., Secy...1966.....*Tallahassee*
WILLIAM M. ROWLETT, M.D...1933.....*Tampa*
ORION O. FEASTER, M.D...1936.....*Long Beach, Miss.*
EDWARD JELKS, M.D...1937.....*Jacksonville*
WALTER C. JONES, M.D...1941.....*Miami*
EUGENE G. PEEK SR., M.D...1943.....*Ocala*
WILLIAM C. THOMAS SR., M.D...1945.....*Gainesville*
JOSEPH S. STEWART, M.D...1948.....*Miami*
WALTER C. PAYNE SR., M.D...1949.....*Pensacola*
ROBERT B. McIVER, M.D...1952.....*Jacksonville*
FREDERICK K. HERPEL, M.D...1953..*Laguna Hills, Calif.*
DUNCAN T. McEWAN, M.D...1954.....*Orlando*
FRANCIS H. LANGLEY, M.D...1956.....*St. Petersburg*
WILLIAM C. ROBERTS, M.D...1957.....*Panama City*
JERE W. ANNIS, M.D...1958.....*Lakeland*
RALPH W. JACK, M.D...1959.....*Miami*
LEO M. WACHTEL, M.D...1960.....*Jacksonville*
ROBERT E. ZELLNER, M.D...1962.....*Orlando*
WARREN W. QUILLIAN, M.D...1963.....*Coral Gables*
SAMUEL M. DAY, M.D...1964.....*Jacksonville*
H. PHILLIP HAMPTON, M.D...1965.....*Tampa*



Ballast Point Manor

5226 Nichols St., P. O. Box 13467 Phone 831-4191
Tampa, Florida

Don Savage, Owner-Manager

Care of mild mental cases, senile disorders and invalids. Alcoholics treated. Aged adjudged cases will be accepted on either permanent or temporary basis.

Anderson Surgical Supply Co.

Established 1916

Distributors of Known Brands of Proven Quality

TELEPHONE 229-8504
Morgan at Platt, P. O. Box 1228
TAMPA, FLORIDA 33601

TELEPHONE 376-8253
236 S.W. 4th Ave.
GAINESVILLE, FLORIDA

TELEPHONE 896-3107
556 9th St., South
ST. PETERSBURG, FLORIDA

TELEPHONE CHerry 1-9589
1818 N. Orange Ave.
ORLANDO, FLORIDA

TUCKER HOSPITAL, INC.

212 West Franklin Street
Richmond, Virginia

A private hospital for diagnosis and treatment of psychiatric and neurological disorders. Hospital and out-patient services.

James Asa Shield, M.D.
George S. Fultz, Jr., M.D.
Catherine T. Ray, M.D.

Weir M. Tucker, M.D.
Edward W. Gamble, III, M.D.
Gerald W. Atkinson, M.D.

A.M.A. HOUSE OF DELEGATES

ROBERT E. ZELLNER, M.D., Delegate.....*Orlando*
RALPH W. JACK, M.D., Alternate.....*Miami*
(Terms expire Dec. 31, 1967)
BURNS A. DOBBINS JR., M.D., Delegate....*Ft. Lauderdale*
WALTER E. MURPHREE, M.D., Alternate.....*Gainesville*
(Terms expire Dec. 31, 1967)
REUBEN B. CHRISMAN JR., M.D., Delegate...*Coral Gables*
SAMUEL M. DAY, M.D., Alternate.....*Jacksonville*
(Terms expire Dec. 31, 1968)
FRANCIS T. HOLLAND, M.D., Delegate.....*Tallahassee*
MADISON R. POPE, M.D., Alternate.....*Plant City*
(Terms expire Dec. 31, 1968)
JERE W. ANNIS, M.D., Delegate.....*Lakeland*
LEO M. WACHTEL, M.D., Alternate.....*Jacksonville*
(Terms expire Dec. 31, 1968)

COUNCIL ON SPECIALTY MEDICINE

SANFORD A. MULLEN, M.D., Chm.....*Jacksonville*

COMMITTEES

Anesthesiology—
JAMES D. BEESON, M.D...1971.....*Jacksonville*
Dermatology—
JACK H. BOWEN, M.D...1971.....*Jacksonville*
General Practice—
WALTER W. SACKETT JR., M.D...1969.....*Miami*
Internal Medicine—
CHARLES K. DONEGAN, M.D...1968....*St. Petersburg*
Neurosurgery—
EDWARD J. SULLIVAN JR., M.D...1970....*Jacksonville*
Obstetrics and Gynecology—
CURTIS G. ROREBECK, M.D...1969.....*Tampa*
Ophthalmology and Otolaryngology—
JAMES W. CLOWER JR., M.D...1969....*Daytona Beach*
Orthopedics—
JOSEPH G. MATTHEWS, M.D...1971.....*Orlando*
Pathology—
SANFORD A. MULLEN, M.D...1968.....*Jacksonville*
Pediatrics—
J. ALFRED BOWERS, M.D...1968.....*Jacksonville Bch.*
Plastic Surgery—
BERNARD L. N. MORGAN, M.D...1969....*Jacksonville*
Psychiatry—
SAMUEL G. HIBBS, M.D...1971.....*Tampa*
Radiology—
ANDRE S. CAPI, M.D...1968.....*Ft. Lauderdale*
Surgery—
EMMET F. FERGUSON JR., M.D...1970....*Jacksonville*
Urology—
DAVID W. GODDARD, M.D...1970.....*Daytona Beach*

Subcommittee on Specialty Groups:

MELVIN NEWMAN, M.D.,
Florida Allergy Society.....*Jacksonville*
GEORGE T. EDWARDS, M.D.,
Florida Society of Anesthesiologists*Fort Lauderdale*
CHARLES H. LASLEY, M.D.
Florida Chapter, American College of
Chest Physicians.....*Clearwater*
ARNOLD R. GODDARD, M.D.,
Florida Society of Dermatology*Coral Gables*
WILLIAM P. CLARKE, M.D.,
Florida Academy of General Practice.....*Jacksonville*
ABBOTT Y. WILCOX JR., M.D.,
Florida Society of Internal Medicine.....*St. Petersburg*
FRANCIS L. MERRITT JR., M.D.,
Florida Society of Neurology.....*Lakeland*
HOWARD C. CHANDLER, M.D.,
Florida Neurosurgical Society.....*Jacksonville*
JOSEPH W. PILKINGTON, M.D.,
Florida Obstetric and Gynecologic Society....*St. Petersburg*
CHARLES F. McCRORY, M.D.,
Florida Society of Ophthalmology.....*Jacksonville*
ROBERT J. PFAFF, M.D.,
Florida Orthopedic Society.....*Lakeland*
WEST BITZER, M.D.,
Florida Society of Otolaryngology.....*Ocala*
WILLIAM F. MAHONEY, M.D.,
Florida Society of Pathologists.....*Sarasota*
THOMAS M. BRILL, M.D.,
Florida Pediatric Society*Gainesville*
BRUCE B. SUTTON, M.D.,
Florida Society of Physical Medicine
and Rehabilitation.....*Coral Gables*
ROBERT L. WELLS, M.D.,
Florida Society of Plastic and
Reconstructive Surgery*St. Petersburg*
E. CHARLTON PRATHER, M.D., Florida Society of
Preventive Medicine.....*Orange Park*
JOHN T. McCORMICK, M.D.,
Florida Proctologic Society*Jacksonville*
ARNOLD H. EICHERT, M.D.,
Florida Psychiatric Society.....*Hollywood*
MALCOLM S. VAN de WATER, M.D.,
Florida Radiological Society.....*Windermere*
HARRY W. REINSTINE JR., M.D.,
Florida Chapter, American College
of Surgeons.....*Jacksonville*
JESSE W. CASTLEBERRY, M.D.,
Florida Association of General Surgeons.....*Orlando*
WENDELL J. NEWCOMB, M.D.,
Florida State Surgical Division,
International College of Surgeons.....*Pensacola*
VICTOR A. POLITANO, M.D.,
Florida Urological Society.....*Miami*

COUNCIL ON VOLUNTARY HEALTH AGENCIES

MASON ROMAINE III, M.D., Chm.....*Jacksonville*
MASON ROMAINE III, M.D.,
Florida Heart Association.....*Jacksonville*
LOUIS M. SALES, M.D., Florida Chapter,
The Arthritis Foundation.....*Jacksonville*
CHARLOTTE C. MAGUIRE, M.D., Florida Society
for Crippled Children and Adults.....*Orlando*
EARL E. WILKISON, M.D., Florida Division,
American Cancer Society.....*Tallahassee*
FRANK L. CREEL, M.D., Florida Association
for Mental Health.....*Pensacola*
HAWLEY H. SEILER, M.D., Florida Tuberculosis
and Respiratory Disease Association.....*Tampa*
THOMAS S. EDWARDS, M.D., Florida Society
for Prevention of Blindness.....*Jacksonville*
CHARLES H. CARTER, M.D., Florida Association
for Retarded Children.....*Orlando*
GORDON R. HEATH, M.D., United Cerebral
Palsy of Florida.....*Lakeland*
THEODORE A. DIPPY, M.D.,
The National Foundation.....*Winter Park*
RUTH A. RICE SIMONS, M.D.
National Multiple Sclerosis Society.....*Coral Gables*

FLORIDA MEDICAL FOUNDATION

EUGENE G. PEEK JR., M.D., President*Ocala*
WILLIAM J. DEAN, M.D., Vice President....*St. Petersburg*
FLOYD K. HURT M.D., Secretary-Treasurer....*Jacksonville*

INVESTMENT PLAN COMMITTEE

FLOYD K. HURT, M.D., Chm.....*Jacksonville*
BURNS A. DOBBINS JR., M.D.....*Ft. Lauderdale*
CARL S. McLEMORE, M.D.....*Orlando*
JOHN D. MILTON, M.D.....*Coral Gables*
WILLIAM M. C. WILHOIT, M.D.....*Pensacola*
JOHN M. BUTCHER, M.D.....*Sarasota*
JOHN J. CHELEDEN, M.D.....*Daytona Beach*
WILLIAM J. DEAN, M.D.....*St. Petersburg*
JAMES J. DeVITO, M.D.....*St. Augustine*
GEORGE S. PALMER, M.D.....*Tallahassee*
JOSEPH C. VON THRON, M.D.....*Cocoa Beach*
JAMES L. ANDERSON, M.D.....*Miami*

LEGAL COUNSEL

MARKS, GRAY, YATES, CONROY & GIBBS....*Jacksonville*

CERTIFIED PUBLIC ACCOUNTANTS

LUCAS, HERNDON, HARMS AND LUCAS....*Jacksonville*

Index To Volume 54

January - December 1967

Abdominal Pregnancy (Scientific) ... 566
Alcoholics and Alcoholism Treatment (Scientific) ... 349
Amebiasis (Editorial) ... 575
Amebiasis (Scientific) ... 562
Amebiasis in South Florida (Scientific) ... 1062
Angina Pectoris, Treatment (Scientific) ... 116
Angina Pectoris, Treatment (Editoral) ... 144
Annual Meeting:
- Schedule of Activities ... 359
- Scientific and Guest Speakers ... 362
- President's Address—A Proud Legacy ... 643
- Ninety-Third Annual Meeting (Editorial) ... 727
- Ninety-Third Annual Meeting General Session ... 647
- First House of Delegates ... 653
- Second House of Delegates ... 660
- Index to Proceedings, Ninety-Third Annual Meeting ... 743

Antiarrhythmic Agent, Lidocaine (Scientific) ... 1137
Anticoagulant Therapy (Scientific) ... 569
A Venerable Institution (Others Are Saying) ... 859
Association News:
- Advisory Committee to Blue Shield ... 172
- AMA Opposes Blue Shield Schedules ... 1078
- AMA Policy on Chiropractic ... 314
- AMA Reaffirms Support of all Nursing Education Programs ... 1078
- AMA Urged to Endorse Federal Support of Research ... 314
- Board of Governors of Florida Medical Association Meeting ... 285
- Committee on Aging ... 171
- Committee on Health Insurance ... 171
- Committee on Mental Health ... 171
- Committee on Mental Retardation ... 1077
- Committee on Rural Health ... 590, 1077
- Committee on Scientific Assemblies ... 1077
- Confidential and Privileged Communications ... 1083
- Council on Legislation and Public Agencies ... 172
- Council on Voluntary Health Agencies ... 1077
- Council on Specialty Medicine ... 172, 1078
- Doctor's Dilemma to be Examined at AMA Convention ... 475
- Ethical Responsibilities Regarding Prescriptions ... 476
- FMA Investment Plan Available to Members ... 1078
- Florida Joint Council on Health of the Aging ... 1077
- Letter to AMA Insurance Participants ... 589
- 1967 Florida State Science Fair Awards ... 592
- Ninth Annual County Medical Society Presidents and Secretaries Conference ... 60, 284
- Nursing Home Care Clarified ... 475
- Professional Courtesy ... 1010
- Putnam Physicians Establish Scholarship Fund ... 286
- Report of Ad Hoc Committee on Resolution 67-22 ... 1078
- Report of the Blue Shield Board of Directors Ad Hoc Committee on Pathology ... 172
- Venomous Snakebite Subcommittee Meeting ... 1077
- Woman's Auxiliary Wins HEW Award ... 830
- World Medical Association Membership Open ... 830

Back Disorders in Children (Scientific) ... 958
Back Operations, Decision of Care (Scientific) ... 964
Back Pain, Adult Postural (Scientific) ... 956
Books Received ... 488
Breast Cancer, Management (Scientific) ... 111

Carcinoma of the Cervix in Pregnancy (Scientific) ... 1127
Carcinoma of the Vulva (Scientific) ... 138
Central Nervous System Lesions (Scientific) ... 238
Chest Injuries, Emergency Treatment (Scientific) ... 120
Cleft Palate, Otological Manifestations (Scientific) ... 1047
Colitis, Management (Scientific) ... 872
Combinations of Medical Men (Others Are Saying) ... 547
Continuing a Tradition (Editorial) ... 771
Contraceptive Devices (Scientific) ... 217
Creeping Eruption, Treatment (Scientific) ... 1059
Creeping Eruption (Editorial) ... 1070

Deaths—Members
- Alexander, Robert M., West Palm Beach ... 729
- Arango, Roger J., Miami ... 1106
- Bartleson, Fred D., Fort Myers ... 1018
- Blackmon, Heyward J., Tampa ... 1106
- Blake, William C., Tampa ... 1106
- Blalock, Shateen T., Winter Park ... 1018
- Borland, James L. Sr., Jacksonville ... 1018
- Calhoon, Jay W., Fort Lauderdale ... 729
- Cameron, Fay A., Tampa ... 729
- Cato, Turner E., Miami ... 1106
- Cook, Henry M., Tampa ... 729
- Corlew, Edith P., Tampa ... 729
- Daniels, James P., Pensacola ... 729
- Day, Horace A., Orlando ... 730
- Donegan, Charles C. Jr., Fort Myers ... 730
- Dowling, Jasper B., Marianna ... 1018
- Fellows, William W., Miami ... 1106
- Fleming, Samuel W., West Palm Beach ... 510
- Glicksman, Herbert Y., West Palm Beach ... 510
- Goodless, Maxwell D., Hollywood ... 730
- Holly, John C. Sr., Milton ... 510
- Horne, Hendly F., Jacksonville ... 1018
- Hughes, John A., Fort Lauderdale ... 730
- Johnston, Hewit, Orlando ... 731
- Kafka, Maximillian M., Kendall ... 1019
- Lambdin, Ludlow, St. Petersburg ... 82
- Lester, John G., Lakeland ... 510
- McSween, John C., Pensacola ... 1106
- Mendelblatt, David L., St. Petersburg ... 1107
- Morse, George W., Pensacola ... 1019
- Murphy, Chester H., Bartow ... 82
- Nowling, James C., Jupiter ... 731
- Payton, Frazier J., Miami ... 731
- Pearson, Homer L., Miami ... 651
- Pines, John A., Orlando ... 732
- Read, John S., Savannah, Ga. ... 510
- Richardson, George W., Jacksonville ... 82
- Roberts, Earl H., Jacksonville Beach ... 1107
- Royer, Don J., West Palm Beach ... 82
- Sinden, Richard H., St. Petersburg ... 82
- Snow, Thomas A., Gainesville ... 732
- Stepner, A. Lester, Miami ... 732
- Waldron, B. Robbins, St. Petersburg ... 732
- White, Paul L., St. Petersburg ... 1107
- Wilhoit, Sterling, Quincy ... 1107
- Woodville, John B. Jr., St. Petersburg ... 510
- Wright, Peter B., Orlando ... 1107
- Young, David R., Palatka ... 1107

Decision . . . In the Wrong Hands (Others Are Saying) ... 147
Disability Evaluation of the Back (Scientific) ... 962
Diuretic Effects of Triamterene (Scientific) ... 241
Don't Confuse Me With the Facts (Editorial) ... 890

Electrocardiogram (Scientific) ... 1104
Esophagus, Spastic (Scientific) ... 882

50 Years Ago in the Journal ... 819, 906, 1006, 1087, 1172

Glimpses of Florida Medical History (Editorial) 755
Good Health to All (Others Are Saying) 858
Good Old Doc's Busier Than Ever (Others Are Saying) 268
Good Old Doc Is Not Dead (Editorial) 143
Government News:
AMA Medicare and Medicaid Changes 1074
Anesthesiology Grant Program 953
Drug Practices 1176
Federal Government Institutes Alcoholism Control Program 74
Head Start 1176
Heart Study Grants Announced 908
HEW Secretary Urges Expanded Medicare 951
HEW Task Force Studies Medicare Drug Question 716
Hospital-Based Physicians Subject of SSA Study 278
Lung Cancer Task Force Appointed by Federal Government 1075
Medicare Changes Recommended by SSA Commissioner Ball 278
NIH Artificial Heart Research 164
90th Congress to Consider Medicare and Medicaid Amendments 73
Obesity a Major Health Problem 165
Physicians Not Obligated to Answer Medicare Survey 277
Granuloma, Eosinophilic of Lung (Scientific) 347

Heart Block, Endocardial Pacing (Scientific) 128
Heart Disease, Congenital (Scientific) 329
Heart Murmur, School-Age Child (Scientific) 135
Heart Surgery, Early Care (Scientific) 1051
Heart Surgery, Patient Care (Editorial) 1069
Hillsborough County Demonstration Project (Editorial) 145
History of Mental Health in Florida (Scientific) 809
Homer Lee Pearson, M.D., In Memoriam 651
Hyperthyroidism, Congenital (Scientific) 343
Hyperthyroidism, Neonatal (Editorial) 355

In Defense of Doctors (Others Are Saying) 78
Infantile Pyloric Stenosis (Scientific) 1139
Infantile Pyloric Stenosis (Editorial) 1161
Infections Due to Common Bacteria (Scientific) 876
In Memory of Good Old Doc (Others Are Saying) 268
Intrauterine Device Insertion (Scientific) 887

Jackson Memorial Hospital:
A Half Century of Community Service 785
John Gorrie, M.D. 797
John Moultrie Jr., M.D. 772
Joseph Yates Porter, M.D. 801
Jugulargraphy as a Diagnostic Technique (Scientific) 339

Kidney, Congenital Unilateral Multicystic (Scientific) 884
Legislative Report (Others Are Saying) 1167
Let There Be Light (Editorial) 1159

Letters to the Editor 273, 399, 516, 596, 768, 1099, 1185
Lumbosacral Strain, Treatment (Scientific) 968

Medical Detective:
Disputed Parentage 1093
Go to the Scene 1170
Hazards of the Convention Goer 827
Hit and Run Victim? 160
Motel Deaths 425
Problems in the Blue 635
Rapture of the Deep 940
Slaughter of the Innocents 256
The Case of the Charred Skin 604
The Sunday Gardener 865
The Thin Thread of Life 63
Medical Inpatients' Attitudes Toward Physicians and Hospitalization (Scientific) 1056
Medicare Reimbursement Program (Others Are Saying) 857
Medical Licenses Granted 404
Medicine and Religion (Editorial) 977
Meetings 75, 163, 295, 398, 516, 598, 728, 822, 826, 986, 1014, 1103, 1186
Meetings (National and Regional in Florida) 291, 390, 426, 728, 822, 1014, 1100, 1187
Mental Retardation(Scientific) 1147

Observations on Financing Medical Care (Editorial) 976
Old Doc is Glad He's Now a Relic (Others Are Saying) 522
"Old Timey Remedies" 778
Osteoporosis in the Aged Spine (Scientific) 972

Pancreatitis, Acute Hemorrhagic (Scientific) 564
Pancreatitis, Acute Hemorrhagic (Editorial) 577
Perinatal Mortality Problem in Florida (Scientific) 231
Pneumonia, Fatal Pneumocystis in an Adult (Scientific) 869
Pathology Practice in Florida (Scientific) 799
Pregnancy, Abdominal (Scientific) 566
President's Page:
Changing Trends 751
It Was A Very Good Year 421
Legislation—1967 245
1967: A New Year—A New Outlook 46
Ninth Annual County Medical Society Presidents and Secretaries Conference 140
Nursing Shortage 938
Spirit of Giving 1121
That the Past, Present and Future Be Preserved 353
The Democratic Approach 711
The Doctor in His House 1031
The Journal—53 Years of Service 852
Williams Dean Steward, M.D. 573
Public Health Page:
Did You Protect the Spread? 1038
Fragile Physicians 498
Home Nursing Care 161
Measles Eradication 280
Medical History Coming Alive 601
Parathion Poisoning 1183
Research 627
Screening for Glaucoma 837
The New Face of Leprosy 904
The Physician and Syphilis Control 76
Tuberculosis Today and Tomorrow 389

Renal Insufficiency Treatment (Scientific) 1144
Report of Ad Hoc Committee on Resolution 67-22 (Editorial) 1071
Research:
Research at the University of Miami School of Medicine 15
Department of Anatomy 16
Department of Anesthesiology 17
Department of Biochemistry 19
Department of Dermatology 21
Department of Medicine 23
Department of Microbiology 26
Department of Neurology 28
Department of Obstetrics-Gynecology 30
Department of Ophthalmology 31
Department of Pathology 34
Department of Pediatrics 36
Department of Pharmacology 38
Department of Physiology 40
Department of Psychiatry 41
Department of Radiology 42
Department of Surgery 44
University of Miami School of Medicine Student Research papers 433
University of Florida College of Medicine Student Research papers 451
Respiratory Distress in the Newborn (Scientific) 1130
Respiratory Distress in the Newborn (Editorial) 1161

Special Articles:
A Month With Medico in Afghanistan ... 378
A Physician's Bible Study ... 247
A Rubeolad Classic ... 988
Automotive Crash Injury Research Study ... 253
Back to Fee Schedules? ... 542
By the Numbers ... 997
Future Trends of Psychiatry ... 892
Liberal Abortion Laws ... 916
On Being Fifty ... 825
On the Profession of Medicine ... 581
Partnership Between Practice of Medicine and Educational Institutions ... 607
Problems in Medical Education in Florida ... 554
Reading is What's Happening ... 373
Relative Value Studies ... 485
RX- Professional Liability ... 921
Smoking and Accidents ... 261
So You Want to Write an Article ... 979
Spine Fractures Involving the Trunk (Scientific) ... 960
Symposium on Back Problems (Editorial) ... 955

The Doctor and Criminal Responsibility (Scientific) ... 559
The Patient, A Symptom of the Family (Scientific) ... 125
The Two-Pounds-A-Week Deal (Scientific) ... 228
The Seven Pillars of Sanity (Editorial) ... 246
The Unhappy Doctor (Others Are Saying) ... 549
Tomorrow's Hospitals—Today (Editorial) ... 1159

Vaginal Smears, Hormone Interpretation (Scientific) ... 132
Vaginitis, Monilial—Male Aspect (Scientific) ... 337

Wound Closure (Scientific) ... 219

Authors

Allgood, Jackson L. Jr., Jacksonville ... 566
Anderson, W. A. D., Miami ... 34
Antell, Gunnard J., Miami ... 231
Aponte, Joseph F., Gainesville ... 1056
Baird, William L. Jr., Bradenton ... 347, 882
Baker, Collin, Tampa ... 890
Barrett-Connor, Elizabeth, Miami ... 1062
Barrow, Mark V., Jacksonville ... 778
Bartlett, J. W., Gainesville ... 469
Bartley, Thomas D., Gainesville ... 329, 1069
Bebout, Donald E., Delray Beach ... 997
Beck, J. Walter, Miami ... 1062
Belle, Martin S., Miami ... 116
Beller, Harry E., Miami ... 597, 977
Belluccia, Giuseppe, Tampa ... 241
Berkshire, Mary Helen, Gainesville ... 1056
Blank, Harvey, Miami ... 21
Blank, Richard H., Tampa ... 1130
Boling, Davis S., Tampa ... 960
Bond, James O., Jacksonville ... 498, 979
Bradley, Matthew H., Miami Beach ... 569
Caldwell, John, Miami ... 41
Carlton, Leffie M., Tampa ... 1130
Carpenter, Donald, Orlando ... 1147
Carter, Charles H., Orlando ... 1147
Carson, Doris N., Jacksonville ... 887
Castellano, Giuseppe C., Tampa ... 869
Castillo, Cesar, Miami ... 128
Center, Sol, Miami ... 128
Chandler, James R., Miami ... 339
Collins, Thomas E., Jacksonville ... 904, 988
Connar, Richard G., Tampa ... 1130
Crotzer, Malcolm C., Fort Walton Beach ... 562
Davidson, Eugene T., Lakeland ... 111
Davies, John E., Miami ... 1183
DeHaan, Quentin C., Bartow ... 217
Deichmann, William B., Miami ... 38
De La Torre, Alberto, Miami ... 125
Denman, Sidney B., Gainesville ... 1056
Dennis, Michael T. B., Gainesville ... 465
DeVito, James J., St. Augustine ... 768
Dobbins, Patrick K., Gainesville ... 452
Dobrin, Max, Miami Beach ... 598
Dyrenforth, Lucien Y., Jacksonville ... 799
Eckert, William G., Wichita, Kan. ... 63, 160, 256, 425, 604, 635, 827, 865, 940
Ehrenkranz, N. Joel, Miami ... 876
Farrington, Joseph A., Jacksonville ... 1070
Ellwood, Leslie C., Gainesville ... 460
Fazio, Frank V., St. Petersburg ... 884
Ferguson, Thomas B., St. Louis, Mo. ... 120
Ferren, Frank A. Jr., Miami ... 434
Fishbein, I. Leo, Miami Beach ... 246
Foraker, Alvan G., Jacksonville ... 799
Foster, Malcolm T. Jr., Gainesville ... 575
Frame, Eugene M., Jacksonville ... 343
Fulghum, James E., Jacksonville ... 261
Gamble, James E., Miami ... 339
Gates, Emily H., Tampa ... 280
Geelhoed, Glenn W., Ann Arbor, Mich. ... 581
Gilbert, Michel, Miami ... 1139
Gilpin, Charles A., Miami ... 337
Guest, James L. Jr., Gainesville ... 329
Hammond, Daniel O., Miami ... 132
Hampton H. Phillip, Tampa ... 145, 976
Hardee, E. B. Jr., Vero Beach ... 727
Hardy, Albert V., Jacksonville ... 77, 389, 601, 627
Harrington, William J., Miami ... 23
Hawkins, Paul, Jacksonville ... 921
Hester, Marion W., Lakeland ... 837
Holland, Francis T., Tallahassee ... 253
Jacobson, Lawrence H., Orlando ... 598
Jannach, Joseph R., Miami ... 876
Jelks, Edward, Jacksonville ... 797
Judd, Allyn F., Delray Beach ... 997
Jude, James R., Miami ... 1051
Kahana, Lawrence, Tampa ... 238, 241, 1144
Kahana, Shirley, Tampa ... 238
Keiser, Robert P., Coral Gables ... 958
King, Hueston C., Miami ... 1047
Krovetz, L. Jerome, Gainesville ... 329
Kulvin, Max M., Miami ... 516
Larson, E. Arthur, Gainesville ... 892
Lauth, Edward J., Miami ... 916
Lefkowitz, Sidney ... 1159
Lewis, George T., Miami ... 19
Lindau, Warren, Miami ... 1104
Little, William A., Miami ... 30
LoCicero, Felix, Tampa ... 1144
Lombardo, Carlos R., Miami ... 1051
McCranie, Peter A., Jacksonville ... 887
McCris, Jack A., St. Petersburg ... 274, 542
McHenry, L. E., Melbourne ... 1170
McMichael, Peter D., Miami ... 876
McPherson, Harry, Tampa ... 238
Manry, Willard E. Jr., Lake Wales ... 228
Marder, Leon, Los Angeles, Calif. ... 872
Mathison, Enid, Jacksonville ... 161
Mead, Charles A. Jr., Jacksonville ... 956
Mencia, L. Felipe, Miami ... 1139
Menzies, Donald, Gainesville ... 138, 564
Michael, Max Jr., Jacksonville ... 554, 778
Miller, Wallace E., Miami ... 964
Mobin-Uddin, Kazi, Miami ... 1051
Moran, James D., Bradenton ... 347
Moseley, Thad, Jacksonville ... 771, 955
Mullee, Robert, Gainesville ... 1127
Moya, Frank, Miami ... 17
Narot, Joseph R., Miami ... 597
Newcomb, Wendell J., Pensacola ... 962
Newman, Gustave, Gainesville ... 559
Nicholson, Hayden C., Miami ... 15, 16, 433
Noble, James P., Miami ... 444
Northcott, Eugene F., Miami ... 1047
Norton, Edward W. D., Miami ... 31
Nyhan, William L., Miami ... 36, 1147
Oldham, Nora B., Miami ... 135
Parks, Raymond E., Miami ... 42
Payne, Henry H. Jr., Jacksonville ... 566
Persoff, Myron M., Miami ... 438

Pfaff, Robert J., Lakeland 968
Pilapil, Virgilio R., Jackson, Miss. 343
Pinkston, John A., Miami 448
Prather, E. Charlton, Jacksonville 280, 1038
Price, Robert, Tampa 1144
Prystowsky, Harry, Gainesville 138, 564, 1127
Qualey, J. Robert, Tampa 577
Quehl, Thomas M., St. Petersburg 349
Quillian, Warren W., Miami 269, 1071
Quillian, Warren W. II, Coral Gables 355
Raborn, Robert E., Delray Beach 997
Ring, Gordon C., Miami 40
Ruffolo, Eugene H., Tampa 869
Sallman, Bennett, Miami 26
Samet, Philip, Miami 128
Sams, Robert E., St. Petersburg 884
Schafer, Walter L., St. Petersburg 884
Scheinberg, Peritz, Miami 28, 596
Schiebler, Gerold L., Gainesville 329
Schiff, Arthur F., Miami 273
Schwab, John J., Gainesville 1056
Seay, Mary E., Gainesville 457
Shocket, Everett, Miami Beach 378
Slaughter, Frank G., Jacksonville 399, 1159
Slonim, Ralph, Miami 135
Smith, J. Lawton, Miami 247
Smith, Prentiss, E., Miami 1051
Snow, John W., Jacksonville 219
Snowden, Robert, Nashville, Tenn. 261
Sowder, Wilson T., Jacksonville 161, 801, 979
Sperber, Perry A., Daytona Beach 1059
Stenger, Vincent G., Gainesville 1127
Stewart, Franz, Miami 144
Stewart, Joseph, Miami 651
Stover, Ann Spears, Miami 809
Straight, William M., Miami 755, 785
Suter, Emanuel, Gainesville 273, 451, 607
Van Cleve, Robert B., Jacksonville 1137
Vaughn, Rufus M., Gainesville 559
Waring, Joseph I., Charleston, S. C. 772
Warren, W. Dean, Miami 44
Weaver, James M., Fort Lauderdale 1161
Webb, H. Warner, Jacksonville 1161
Welsh, Russell L., New Smyrna Beach 549
West, James L., St. Petersburg 972
Wharton, Dwight J., Jacksonville 389
Wheat, Myron W. Jr., Gainesville 329
Whitley, W. M., Miami 442
Williams, Broward, Tallahassee 261
Zellner, Robert E., Orlando 143, 173, 485

Information for Authors

Manuscripts submitted for publication in the Journal of the Florida Medical Association should be double or triple spaced on white bond, including title page, illustration legends, charts and graphs, table headings, footnotes and bibliography.

Submit *original* manuscript and two copies. Copying by electrostatic dry process (not wet process) is preferred to tissue copies. Retain one additional copy in your office for proofreading. All material is submitted with the understanding it is subject to editing.

Photographs should be submitted as 5x7 glossy prints, untrimmed and unmounted; number each photograph *lightly* on the back with pencil and indicate top. Charts, graphs and medical illustrations should be submitted as india ink drawings on white gloss paper; remember to make details large enough to allow for photographic reduction. It is a policy of the Journal that authors pay for any cuts made to illustrate their papers.

Titles should be short, specific and clear. Omit phrases such as "The Use of," "Observations on." If paper was presented at a meeting, indicate name of organization, city, month, day and year.

Only original papers not previously published are accepted for publication. Manuscripts submitted for publication are subject to review and approval by the Journal Publications Committee. Except by invitation, only papers from members of the Florida Medical Association are considered for publication.

References should be typewritten, double or triple spaced, beginning on a new sheet of paper entitled "References." Number references in the text in order of citation and prepare bibliography in the same order. Bibliographies should conform to the style of the Index Medicus. The Journal prints only bibliographies of eight references or less; bibliographies of more than eight references are referred to at the end of the paper with the statement "References are available from the author upon request."

All manuscript pages should be numbered consecutively. Within the manuscript, numbers one to nine should be spelled out except when used for units of measurement; for numbers above nine, numerals should be used. Dorland's Medical Dictionary and Webster's International Dictionary may be used as standard references. Scientific names for drugs should be used when possible. Copyright or trade names of drugs should be capitalized.

Index to Advertisers

Abbott Laboratories
Erythrocin Sulfas 1164-1166

Ames Co.
Icotest 1187
Labstix 1186

Anderson Surgical Supply Co. 1197

Appalachian Hall 1195

Armour Pharmaceutical Co.
Letter 1174

Associated Management 1177

Ballast Point Manor 1197

Burroughs-Wellcome Co.
Empirin 1190a

Campbell Soups 1158a

Coca Cola 1193

Conal Pharmaceuticals
Urised 1118a

Convention Press 1166

Dorsey Laboratories
Tussagesic 1166a

Duvall Home 1186

Geigy Pharmaceuticals
Butazolidin 1168-1169
Hygroton 1124-1125

Highland Hospital, Inc. 1190

Hill Crest Hospital 1193

Hynson, Westcott & Dunning, Inc.
Lutrexin 1115

Lakeside Laboratories, Inc.
Cantil 1166a
Imferon 1118
Mercuhydrin 1182
Norpramin 1178

Lederle Laboratories
Declomycin 1202a
Stresscaps 1182a

Eli Lilly & Co.
Tes-Tape 1126
Tuinal 1166a
V-Cillin K 1158

Medical Supply Co. 1177

Parke-Davis & Co.
Dilantin Second Cover

Pediatric Care Center 1098

Pitman-Moore Co.
Novahistine LP 1122-1123

P. L. Dodge Memorial Hospital 1195

PM of Florida 1166

William P. Poythress & Co.
Mudrane 1182a
Solfoton 1163
Synirin 1162
Trocinate 1173

A. H. Robins, Inc.
Donnagel 1174a
Robaxin 1190a
Robitussin 1174a, 1175

Roche Laboratories
Valium Back Cover

Rystan Company
Chloresium 1171

Sandoz
Mellaril 1182a

G. D. Searle Co.
Metamucil 1158a

Smith Kline & French Laboratories
Ornade 1181

Stamas Boats 1119

Stuart Co.
Mylanta 1120

Surgical Supply Co. 1195

Syntex Laboratories
Norinyl 1190a
Synalar 1190a

Tucker Hospital, Inc. 1197

Winthrop Laboratories
NegGram 1116
Talwin 1198a



Tears without grief

LIBRARY
DEC
NEW YORK ACADEMY OF MEDICINE

Crying Spells–psychic tension with depressive symptoms?

"I don't know what's the matter with me lately...I cry and I cry... and I really don't know why I do."

A woman often is not conscious of the real reasons for her crying spells or refuses to admit them to herself. On probing, you may find that frequent weeping, like insomnia or neurotic fatigue, often is an expression of psychic tension. She needs sympathy and reassurance, and perhaps a calming agent to help her over her crisis. Consider prescribing Valium (diazepam) for her. It usually reestablishes calmness promptly. Crying spells and other secondary depressive symptoms normally subside as the tension is relieved. Your patient then can cope more easily with stresses to which she is subjected. Valium (diazepam) is generally well tolerated, and on proper maintenance dosage usually does not impair mental acuity or ability to function. If side effects such as ataxia and drowsiness occur, they usually disappear with dosage adjustment.

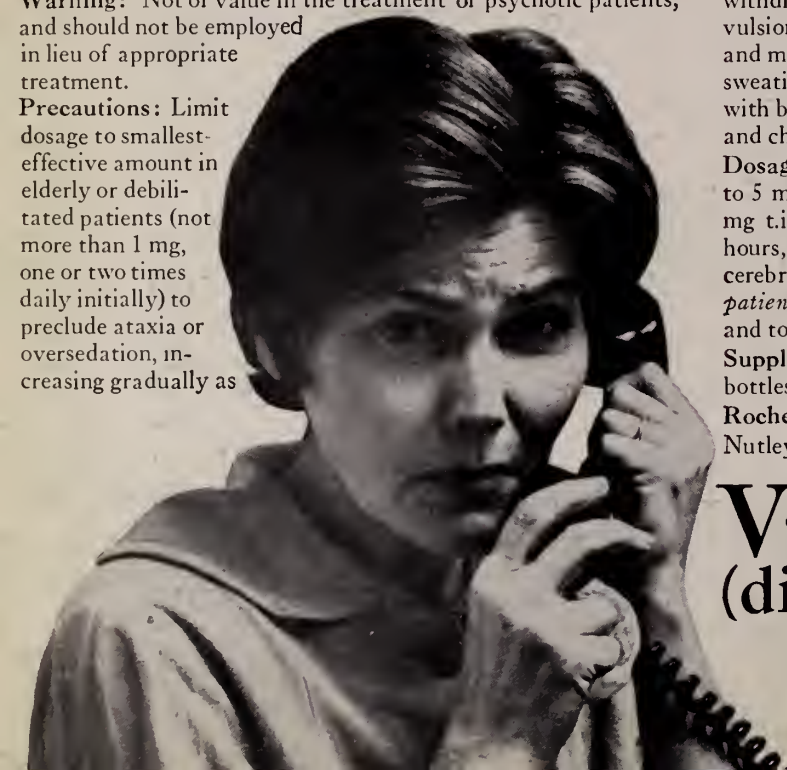


Before prescribing, please consult complete product information, a summary of which follows:

Contraindications: Infants, patients with history of convulsive disorders, glaucoma or known hypersensitivity to drug.

Warning: Not of value in the treatment of psychotic patients, and should not be employed in lieu of appropriate treatment.

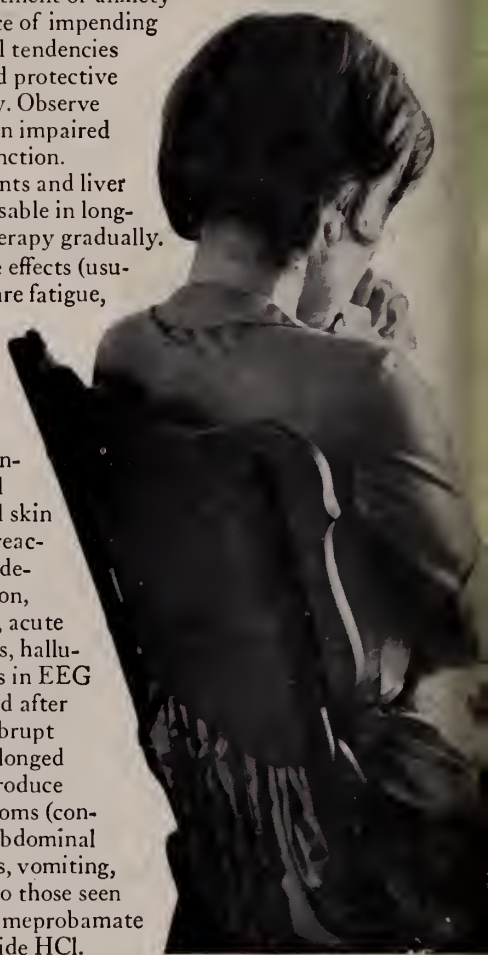
Precautions: Limit dosage to smallest effective amount in elderly or debilitated patients (not more than 1 mg, one or two times daily initially) to preclude ataxia or oversedation, increasing gradually as



New York Academy of Medicine
2 East 103rd St
New York N Y J 12-67
10029

need
corr
agai
tal a
not
tropi
til
ts
n-
py
o-

...is used, carefully consider individual pharmacologic effects—particularly with known compounds which may potentiate action of Valium (diazepam), such as phenothiazines, barbiturates, MAO inhibitors and other antidepressants. Advise patients against simultaneous ingestion of alcohol or other CNS depressants. Safe use in pregnancy not established. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Observe usual precautions in impaired renal or hepatic function. Periodic blood counts and liver function tests advisable in long-term use. Cease therapy gradually.



Side Effects: Side effects (usually dose-related) are fatigue, drowsiness and ataxia. Also reported: mild nausea, dizziness, blurred vision, diplopia, headache, incontinence, slurred speech, tremor and skin rash; paradoxical reactions (excitement, depression, stimulation, sleep disturbances, acute hyperexcited states, hallucinations); changes in EEG patterns during and after drug treatment. Abrupt cessation after prolonged overdosage may produce withdrawal symptoms (convulsions, tremor, abdominal and muscle cramps, vomiting, sweating) similar to those seen with barbiturates, meprobamate and chlordiazepoxide HCl.

Dosage: *Adults:* Mild to moderate psychoneurotic reactions, 2 to 5 mg b.i.d. or t.i.d.; severe psychoneurotic reactions, 5 to 10 mg t.i.d. or q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; muscle spasm with cerebral palsy or athetosis, 2 to 10 mg t.i.d. or q.i.d. *Geriatric patients:* 1 or 2 mg/day initially, increase gradually as needed and tolerated. (See Precautions.)

Supplied: Valium® (diazepam) Tablets, 2 mg, 5 mg and 10 mg; bottles of 50 and 500.

Roche Laboratories, Division of Hoffmann-La Roche Inc.
Nutley, N.J. 07110

1120-32-2

ROCHE

Valium® (diazepam) Roche®

useful for the relief of psychic tension with associated depressive symptoms

The New York Academy of Medicine

DUE IN TWO WEEKS UNLESS RENEWED
NOT RENEWABLE AFTER 6 WEEKS

DATE BORROWED	BORROWER
JUN [illegible]	[illegible]
JAN 2 4 1972	[illegible] HOSP
	5-17